

Health Sciences North

Peer Review

FINAL REPORT

October 9, 2012

Contents

1.0 EXECUTIVE SUMMARY	1
2.0 PEER REVIEW	7
3.0 HEALTH SCIENCES NORTH.....	10
3.1 EVOLUTION TO AN ACADEMIC HEALTH SCIENCE CENTRE	10
3.2 BACKGROUND TO THE PEER REVIEW OF HSN	11
4.0 GOVERNANCE	13
5.0 MANAGEMENT	16
6.0 THE HIP: ACHIEVING A BALANCED BUDGET	17
7.0 POST CONSTRUCTION OPERATING PLAN AND AMBULATORY CLINICS ..	24
7.1 RAMSEY SITE AMBULATORY PLANS	24
7.2 MEMORIAL SITE AMBULATORY PLANS	25
8.0 LONG TERM FINANCIAL PLAN	30
9.0 LONG TERM CAPITAL PLAN	31
10.0 RELATIONSHIP OF HSN WITH PARTNERS AND STAKEHOLDERS	32
11.0 PATIENT FLOW	35
11.1 HSN ED AND ALC PERFORMANCE	35
11.2 ED ADMITTED PATIENT LENGTH OF STAY	39
11.3 ALC MANAGEMENT.....	41
11.4 PATIENT FLOW AND MENTAL HEALTH.....	63
APPENDIX A: REVIEW TEAM RESUMES.....	65
APPENDIX B: INTERVIEWEES.....	70
APPENDIX C: PATIENT FLOW AND ALC EXHIBITS.....	72
APPENDIX D: DOCUMENT REVIEW INVENTORY	84
APPENDIX E: SUMMARY OF RECOMMENDATIONS	86

1.0 *Executive Summary*

Background and Objectives

Health Sciences North is in the process of transitioning its role from that of a large regional referral and community general hospital to become one of two academic health science centres supporting the new Northern Ontario School of Medicine (NOSM). In September 2011, as part of this process, the hospital changed its name from Sudbury Regional Hospital to Health Sciences North (HSN) to reflect this new role. HSN offers a variety of programs and services that meet many patient care needs, with regional programs in the areas of cardiac care, oncology, nephrology, trauma and rehabilitation.

In July 2012, the North East Local Health Integration Network (NE LHIN) Chief Executive Officer, Ms. Louise Paquette contacted Mr. Murray Martin, President and CEO of Hamilton Health Sciences with a request that he undertake this Peer Review of Health Sciences North (HSN). The Peer Review was initiated by the NE LHIN because of their growing concerns about the ongoing high level of Alternate Level of Care patients occupying the acute care beds of HSN, as well as, concerns regarding the ability of the hospital to balance their operating budget in the fiscal year 2012-2013.

Mr. Martin was supported in his review of HSN by several members of his Hamilton Health Sciences leadership team consisting of:

- Ms. Rebecca Repa, President St. Peter's Hospital
- Ms. Sharon Pierson, Director of Quality, Patient Safety & Risk Program
- Mr. Tim Dietrich, Senior Consultant, Process Improvement
- Ms. Cherilyn van Berkel, Transitional Care and Discharge Specialist

The work of the review team was structured to address each element of the Terms of Reference established for the review:

1. The Peer Reviewer will assess the readiness and capacity of hospital governance to support and hold management and medical staff accountable for the implementation of the Hospital Improvement Plan (HIP).
2. The Peer Reviewer will assess the readiness and capacity of hospital management to implement the HIP and account for its results.

3. The Peer Reviewer will review and assess the feasibility of the HIP and Implementation Plan developed in March 2012 that would see HSN achieve a balanced budget by September 30, 2012.
4. The Peer Reviewer will assess the long term financial plan that will enable HSN to maintain an operating surplus in future years and entitle them to receive working funds assistance funding.
5. The Peer Reviewer will review HSN's Post Construction Operating Plan (PCOP) reconciliation to determine impact on operations.
6. The Peer Reviewer will review and assess the feasibility of the business case for the Sudbury Outpatient Clinic.
7. The Peer Reviewer will review the long-term capital and program plans of HSN to ensure alignment with Ontario's Action Plan for Health Care, the priorities of the NE LHIN and reflects population needs.
8. The Peer Reviewer will review the relationship between HSN and its stakeholders – internally, in terms of alignment between the administration, the Board, physicians and staff and externally, between the North East Local Health Integration Network (NE LHIN), NE CCAC, St. Joseph's Continuing Care Centre and the community sector as well as other hospitals in the NE LHIN.
9. The Peer Reviewer will review the Emergency Department (ED) Process Improvement Project (PIP) to determine if all recommendations have been implemented and sustained. (example: access to after hour diagnostics) A special focus on the patient flow and admission process for Mental Health patients will be conducted.
10. The Peer Reviewer will identify possible strategies that could be implemented to improve the flow of patients in the hospital including a review of bed utilization, integrated discharge planning and physician discharge practices. The review will assess the role of the NE CCAC and St. Joseph's Continuing Care Centre in the integrated discharge planning process.

The report of the Peer Review Team presents the findings and recommendations to address the objectives of the review. The key themes of the review follow.

*Governance and
Accountability*

HSN has a skills based Board of Directors supported by an experienced, capable leadership team. There would be benefit in having a stronger culture of clear accountability. The ultimate responsibility for holding the senior leadership of any organization accountable lies with the Board of Directors of that organization.

It is imperative that HSN move toward a highly disciplined, goal-driven environment that aligns organizational priorities and expectations with the MOHLTC and the NE LHIN. The Board can use tools such as the Quality Improvement Plan (QIP) to support alignment and monitoring of success.

A Mission/Vision Statement, Role Statement, Long Range Plan and Strategic Plan are critical to the successful governance and management of a hospital. The Mission and Vision Statements of HSN should drive a Strategic Plan that is linked to Corporate Goals and Annual Objectives. The Goals and Objectives should be expressed with targets that can be measured and linked to accountability processes. It is incumbent upon the Board of Directors of HSN to establish clear annual performance goals for its senior executive and hold those executives accountable for their achievement. Executive Compensation should be tied to achievement of the objectives.

Management

The Reviewers found the HSN leadership team to be an experienced collegial group of health care leaders that operate with a high sense of loyalty and commitment to their organization. Team members appeared to be very engaged and committed to addressing the problems and there are a number of areas of focus that the team will need to embrace to move the organization forward:

Leadership

HSN has significantly more financial and human resources than any other health provider organization in the NE LHIN. It should be incumbent upon the President and CEO of HSN along with the hospital's senior leadership team to reach out to other health provider organizations in the LHIN to explore opportunities for higher levels of collaboration and integration to create a stronger health care delivery system for the residents of North Eastern Ontario. HSN should provide the leadership within the NE LHIN to steer some of the broader initiatives associated with a reduction of ALC and improved quality of services for the residents of the community.

Tools

The reviewers have found that the hospital possesses the tools and infrastructure necessary to support alignment and monitoring of activities and execution of plans. The Board of Directors and Senior Executive can support success and alignment of activity using tools such as the QIP, Hospital Improvement Plan (HIP), etc.

Alignment

Compensation practices at HSN are not consistent with the practices of most other major academic centres in Ontario where normally anywhere from 20% to 30% of the compensation of the Chief Executive Officer and other senior leaders is considered to be at-risk-pay. At-risk pay for Board objectives can help in aligning organizational priorities. It is recognized that the adoption of best practices in utilizing at-risk compensation is now made difficult because of the ongoing freezes to overall levels of compensation. The practice should however still be instituted to create a culture of accountability that in the future can be aligned with any future changes in compensation.

Plans

The review team was unable to find any documentation of the priority goals or objectives for the organization, other than those contained within the QIP. There should be a greater focus on setting clear outcomes and metrics for goals and objectives.

Monitoring

The senior leadership must adhere to much tighter controls on month-to-month variances from the plan. Deviations from the planned activity levels need to be addressed as soon as possible to ensure the organization can achieve the desired outcomes.

Resources

HSN is a busy academic facility with well appointed facilities and equipment to serve the community. The challenges within the community that are facing HSN are not unique to Sudbury. Many of the correct initiatives required to address their problems are underway. However, there is a need to:

- continue to look at the academic mission and capital funding necessary to support this mission,
- achieve final resolution on some revenue assumptions regarding past MOHLTC allocations, and

- review some major programs which are over benchmark for operating dollars.

Planning

Over the course of the last decade, HSN has been focused on bringing legacy organizations together and in addressing its new role as an Academic Health Science Centre (AHSC). It is now appropriate that the hospital proceed with planning as an AHSC with a focus to:

- address financial pressures and maintain a level of service to the community, HSN will need to engage in long term financial and capital planning;
- deliver on the Academic Mission, HSN will need to continue to plan for the research and teaching components and;
- guide goal setting and annual objectives, HSN Board and Executive will need to engage in a Strategic Planning process.

Execution of the Plan

HSN has many initiatives underway that are representative of other teaching hospitals in the province. Evidence of execution is found in such activities as ED PIP and the HIP. HSN is commended for executing ED PIP in a sustained roll-out to achieve quality improvements with evidence of spread of this quality focus into the rest of the organization. HSN also moved into its new facility in 2010 without incident.

ALC initiatives are, however, not yielding the outcomes that HSN requires. The review team has identified that 30% of the time, long waits in the ED for a bed are related to ALC volumes. The significance and magnitude of the ALC issue should be reflected in the identification of ALC as Priority One metric in the hospital QIP and underscored via alignment of ALC with executive goals, objectives and compensation.

HSN is not independently responsible for management of the ALC issue but must assume an even more enhanced leadership role with the NE CCAC and SJCCC to resolve flow issues for the community. The collective ownership and response of all system providers is critical and areas for further and enhanced collaboration include:

- ALC Designation Process
- Escalation Process
- Intensive Case Management
- Home First Philosophy

Seventy percent of the wait times in the ED result from other variables that are influenced and controlled by HSN including:

- Admission Rate
- Length of Stay
- Discharge Planning and Bed Management Processes
- Bed Map
- Scheduled Activity

ALC management strategies must occur concurrently with strategies to address the other impacting variables in order to successfully manage the patient flow issues at HSN and effectively reduce the current admitted wait time for patients in the ED.

Managing to the Plan

HSN has a strong financial team that has developed sophisticated budget planning and data collection. There is a good account of financial history and processes for external benchmarking. HSN has developed an achievable HIP and it was noted that the majority of the actions within the HIP have been implemented. The reviewers have the view that a balanced budget can be achieved.

However, to be successful in achieving these plans, the senior leadership of the organization will need to ensure a detailed review of performance to identify any deviations from plan and develop corrective actions required to return to plan. The focus should be in the large areas of the plan that have not been met including food services and surgery where there has been a variance in volumes of 400 cases YTD in non-wait time categories.

With no evidence of a Long Term Capital or Strategic Plan it is difficult to manage to the plan. The reviewers agree that the Strategic Plan and subsequent Long Term Capital Plan need to be in total alignment with Ontario's Action Plan for Health Care and the priorities of the NE LHIN and reflect the population needs. The Strategic Plan should outline the priority goals of HSN for the next 10 years. A strategy map and balanced score card should be used to ensure the hospital's progress towards the plan implementation.

Conclusion

The clinical resources for HSN appear to be adequate and what could be expected in an AHSC. The Review Team believes there is opportunity for improvement in the ALC issues at HSN. To move forward, HSN must play a critical leadership role in the LHIN to find solutions for the community and all providers must commit to action.

2.0 Peer Review

Concerns about high level of ALC patients and operating budget for FY 2012-2013 at HSN

In July 2012, the North East Local Health Integration Network (NE LHIN) Chief Executive Officer, Ms. Louise Paquette contacted Mr. Murray Martin, President and CEO of Hamilton Health Sciences with a request that he undertake this Peer Review of Health Sciences North (HSN).

The Peer Review was initiated by the NE LHIN because of their growing concerns about the ongoing high level of Alternate Level of Care patients occupying the acute care beds of HSN, as well as, concerns regarding the ability of the hospital to balance their operating budget in the fiscal year 2012-2013.

The Terms of Reference of the review have been:

1. The Peer Reviewer will assess the readiness and capacity of hospital governance to support and hold management and medical staff accountable for the implementation of the Hospital Improvement Plan (HIP).
2. The Peer Reviewer will assess the readiness and capacity of hospital management to implement the HIP and account for its results.
3. The Peer Reviewer will review and assess the feasibility of the HIP and Implementation Plan developed in March 2012 that would see Health Sciences North (HSN) achieve a balanced budget by September 30, 2012.
4. The Peer Reviewer will assess the long term financial plan that will enable HSN to maintain an operating surplus in future years and entitle them to receive working funds assistance funding.
5. The Peer Reviewer will review HSN's Post Construction Operating Plan (PCOP) reconciliation to determine impact on operations.
6. The Peer Reviewer will review and assess the feasibility of the business case for the Sudbury Outpatient Clinic.
7. The Peer Reviewer will review the long-term capital and program plans of HSN to ensure alignment with Ontario's Action Plan for Health Care, the priorities of the NE LHIN and reflects population needs.
8. The Peer Reviewer will review the relationship between HSN and its stakeholders – internally, in terms of alignment between the administration, the Board, physicians and staff and

externally, between the North East Local Health Integration Network (NE LHIN), NE CCAC, St. Joseph's Continuing Care Centre and the community sector as well as other hospitals in the NE LHIN.

9. The Peer Reviewer will review the Emergency Department (ED) Process Improvement Project (PIP) to determine if all recommendations have been implemented and sustained (example: access to after hour diagnostics). A special focus on the patient flow and admission process for Mental Health patients will be conducted.
10. The Peer Reviewer will identify possible strategies that could be implemented to improve the flow of patients in the hospital including a review of bed utilization, integrated discharge planning and physician discharge practices. The review will assess the role of the NE CCAC and St. Joseph's Continuing Care Centre in the integrated discharge planning process.
11. The Peer Reviewer will report to the Chief Executive Officer of the NE LHIN during the review and provide her with a draft report of findings and recommendations no later than September 14, 2012.
12. The Peer Reviewer will present a final report by October 1, 2012.
13. Oversight of achievement of the Implementation Plan will be the responsibility of HSN with accountability to the NE LHIN.

Mr. Martin agreed to undertake the review and produce a report by the end of September 2012. Mr. Martin was supported in his review of HSN by several members of his Hamilton Health Sciences leadership team. More specifically the review team consisted of Mr. Martin, Ms. Rebecca Repa, President St. Peter's Hospital and Ms. Sharon Pierson, Director of Quality, Patient Safety & Risk Program. Several members of Ms. Pierson's team participated in supporting the review process and each made several site visits to Sudbury. Resumes for the review team members are found in Appendix A of this report.

The work of the Review Team was structured to address each element in the Terms of Reference. In conducting their work, the Review Team met with hospital management, clinical leadership, physicians and front line staff at HSN, St. Joseph's Health Centre (SJHC), the NE CCAC and the NE LHIN. A list of staff that met with the Review Team is provided in Appendix B. The team was provided with a wealth of data and activity information as it relates

to the HIP, ALC, ED and HSN's budget. A partial listing of material received and reviewed is contained in Appendix D. All the material received was reviewed and evaluated based on the experience of the Review Team.

*Senior leaders of HSN and
other stakeholders
acknowledged for their
cooperative assistance*

The senior leaders of HSN should be acknowledged for their collaboration, Dr. Denis Roy, President and CEO, Mr. Joe Pilon, Senior Vice-President and Chief Operating Officer (Senior VP/COO), Mr. David McNeil, Vice President Clinical Programs and Chief Nursing Executive (VP Clinical Programs/CNE), Mr. Ben Petersen, Vice President of Finance and Chief Financial Officer (VP Finance/CFO) and a number of Medical Chiefs of clinical departments all made themselves available at very short notice. The members of the NE LHIN Team, the NE CCAC and St. Joseph's Continuing Care Centre should also be acknowledged.

The report and its recommendations are organized with respect to the specific objectives suggested by the Terms of Reference for the review.

3.0 Health Sciences North

3.1 Evolution to an Academic Health Science Centre

Health Sciences North (HSN) reflecting new role for Hospital

Health Sciences North is in the process of transitioning its role from that of a large regional referral and community general hospital to become one of two academic health science centres supporting the new Northern Ontario School of Medicine (NOSM). In September 2011, as part of this process, the hospital changed its name from Sudbury Regional Hospital to Health Sciences North (HSN) to reflect this new role.

In last decade focus has been on consolidation of services

Acute care delivery in Sudbury has gone through a transformative change over the last decade with the consolidation of services previously disbursed amongst the three inpatient hospital sites into one consolidated site which was accommodated by a large expansion to the Laurentian Site. This consolidation was achieved in 2010. The hospital should be congratulated for this achievement. The consolidation required that the hospital develop new operating policies, processes and systems within a new facility, along with bringing three different cultures from the legacy organizations together into a new organization functioning on one site. This consolidation has been a massive undertaking in itself. This consolidation in 2010 was achieved without incident or loss of service to these communities.

A comprehensive array of both community and specialty programs

HSN now delivers a comprehensive array of both community and specialty programs to not only the residents of the Greater Sudbury Region, but the residents in need of specialty services located throughout the NE LHIN. HSN now operates three hospital sites:

- 429 beds at the main (Ramsey) Site,
- 25 (23 adult and 2 pediatric) acute mental health beds at the Kirkwood Site, and
- 30 transitional ALC beds at the Memorial Site recently renamed Sudbury Outpatient Clinic. These beds are scheduled to close on March 31, 2013.

New CEO with mandate to transform HSN into a leading academic centre

Dr. Denis Roy, joined HSN in January 2010 after serving as the CEO of a major academic hospital facility in Montreal. He was given the mandate to transform HSN into a leading academic centre with associated thrusts in both education and research.

The Review Team recognized that the new Sudbury Regional Hospital facility was significantly over budget in the capital cost of

HSN has all of the assets necessary to deliver on its clinical mission

its construction. As a result, the project was stopped and re-scoped. Consequently, key academic support facilities such as conference rooms, class rooms, research space and secretarial support facilities, which are common to all AHSC centres in Ontario, are not provided within the new hospital facility. While there are plans to address some of the identified facility issues, if HSN is to fulfill its academic mission, there will need to be a longer-term strategy developed that will address the more substantive issues including the development of research infrastructure.

HSN has a very seasoned and capable leadership team and is blessed with significant human resources, financial resources and capital resources. While there is further work needed to advance the academic mandate, as an organization, HSN has all of the critical assets necessary to deliver on its clinical mission in accordance with the expectations of the community it serves.

With the focus of the last decade on the consolidation of services and the construction of new facilities, it is now appropriate for HSN to move forward with a broad-based strategic planning process. This will serve to focus HSN over the next decade. It will be essential that the Strategic Plan be aligned and consistent with the priorities of the Ministry of Health and Long Term Care (MOHLTC) and the Strategic Plan priorities of the NE LHIN. It is also critical that in its planning and in its plan, HSN incorporate the development of an effective relationship with the NE LHIN, the NE CCAC, St. Joseph's Continuing Care Centre and other stakeholders, as an essential element in its role in providing acute and rehabilitation services for people living in Northeastern Ontario.

3.2 Background to the Peer Review of HSN

Long ED Waits are impacting patients, staff, and physicians

Despite implementing many patient flow initiatives, HSN continues to experience extremely high Emergency Department wait times particularly for admitted patients. Emergency Department and other HSN physicians have identified concerns regarding quality of care and safety; staff have expressed workload and the same quality of care and safety concerns; and patients and families have been vocal in their frustrations regarding the long waits. HSN stakeholders attribute the ED wait time issue primarily to the number of Alternative Level of Care (ALC) patients.

HSN directed to develop HIP to address 2011/12 operating deficit

HSN had a 2011/12 year-end operating deficit of \$3.3M and a working funds deficit of \$96M. The NE LHIN and MOHLTC have approved a \$70M cash advance for 2012/13. The hospital also has a \$20M line of credit at the bank.

The hospital was directed by the NE LHIN Board in October 2011 to develop a Hospital Improvement Plan (HIP) that would see them balance by September 30, 2012.

The hospital's plan was received in November 2011. A critical piece of the HIP is Post Construction Operating Plan (PCOP) funding from the MOHLTC. The NE LHIN has been asking the MOHLTC since May 2011 to complete the PCOP reconciliation and communicate to both HSN and the NE LHIN the status of these funds and this funding. The hospital is forecasting a surplus for 2012/13 that is contingent on receiving PCOP funding.

4.0 Governance

The focus of this chapter is on the second objective for the review:

The Peer Reviewer will assess the readiness and capacity of hospital governance to support and hold management accountable for the implementation of the HIP.

Culture of clear accountability could be enhanced at HSN

Members of the Review Team met with members of the senior leadership of the hospital, as well as, a number of the chiefs of the clinical departments. The Review Team identified opportunity to enhance priority setting and establish a stronger culture of accountability within HSN. One would expect to see clearly articulated priorities and ongoing rigorous monitoring of adherence to an annual performance plan. The Board does not appear to be holding executives responsible for specific and measurable deliverables.

Compensation practices not comparable to other academic centres in Ontario

The reviewers were presented with recently prepared documents establishing “Guidelines for Executive Performance and Compensation.” Compensation practices at HSN are not consistent with most other major academic centres in Ontario where normally anywhere from 20% to 30% of the compensation of the Chief Executive Officer and other senior leaders is considered to be at-risk-pay. It is common practice that at least half of the Chiefs Executive Officer’s at-risk-pay is subject to achieving a balanced operating budget.

ALC not a Priority One Metric in the QIP

Under the Excellent Care for All Act, it is required that the hospital CEO and Direct Reports at-risk-pay be linked, at minimum, to Priority One indicators identified in the hospital’s Quality Improvement Plan. It is recommended that hospitals identify as Priority One, any metric that is below benchmark and in need of significant improvement. It was very surprising to find that with ALC being the most significant operational issue facing HSN that it was not identified as a Priority One metric.

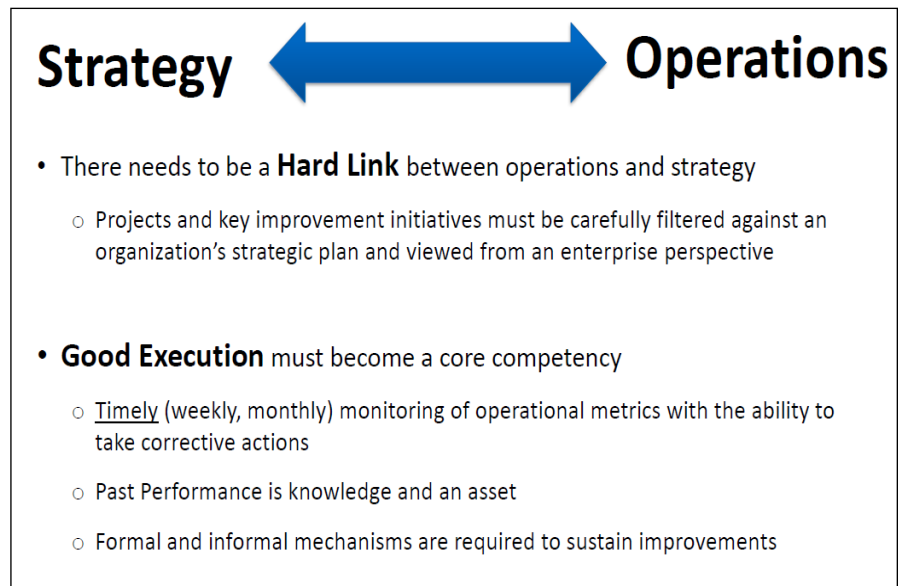
Board should establish clear annual performance goals for senior executive

The ultimate responsibility for holding the senior leadership of any organization accountable lies with the Board of Directors of that organization. It is incumbent upon the Board of Directors of HSN to establish clear annual performance goals for its senior executive and hold those executives accountable for their achievement. It is recognized that the adoption of best practices in utilizing at-risk compensation is now made difficult because of the ongoing freezes to overall levels of compensation. The practice should however still be instituted to create a culture of accountability that in the future

can be aligned with any changes in compensation. The reviewer was unable to find any documentation related to the priority goals or objectives for the organization, other than those contained within the Quality Improvement Plan. The hospital is not setting annual objectives for the organization; nor is it holding the CEO accountable for achieving those objectives.

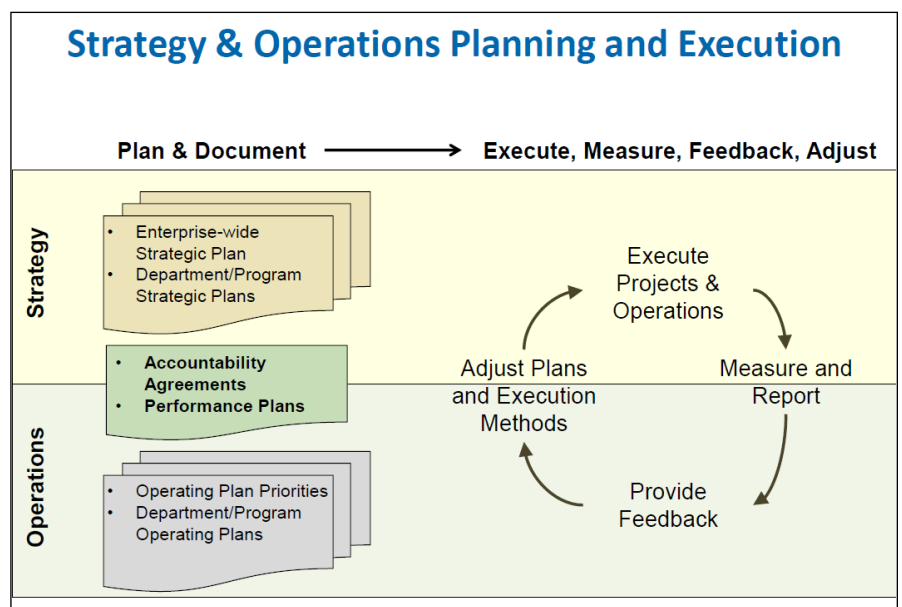
Need for a hard link between strategy and operations

Exhibit 1: Strategy and Operations Link



Execution is an essential competency

Exhibit 2: Strategy to Execution



Recommendations

It is recommended that

- (1) The Board of Directors of HSN annually establish specific goals and/or objectives for the hospital and publicly account for them.**
- (2) The Board of Directors of HSN establish a mechanism to hold the senior leadership of the organization accountable for the achievement of their objectives for the organization.**
- (3) The Board of Directors of HSN tie achievement of the organization's objectives to higher levels of at-risk compensation for the senior leadership of the hospital.**
- (4) The Board of Directors of HSN ensure ALC is identified as a Priority One metric on the 2013/2014 QIP.**

5.0 Management

The focus of this chapter is on the following objective:

The Peer Reviewer will assess the readiness and capacity of hospital management to implement the HIP and account for its results.

A balanced budget can be achieved

The leadership of the organization understands the critical importance of achieving a balanced operating budget for the current fiscal year and is prepared to take actions to ensure that this is achieved. The reviewers assessed the hospital performance for the first quarter of the current fiscal year to ascertain the likelihood that HSN will achieve the goals outlined in the HIP. It was noted that the majority of the actions within the HIP have been implemented and the reviewers have the view that a balanced budget can be achieved.

During the review of the first quarter activity, it was identified that some clinical activities are at levels in excess of plan. It is suggested that the senior leadership adhere to much tighter controls on month-to-month variances from the plan to ensure that deviations from the planned activity levels are addressed as soon as possible to ensure the organization can achieve the HIP.

The CEO, with support from the Vice President of Finance and Chief Financial Officer, should be meeting with his management team on at least a monthly basis to review performance, identify deviations from the HIP and direct specific corrective actions to return to planned levels of performance.

Recommendation

It is recommended that

- (5) The HSN CEO with support from the VP Finance/CFO undertake, on a monthly basis, a detailed review of performance to identify any deviations from plan and develop corrective actions required to return to plan.**

6.0 The HIP: Achieving a Balanced Budget

The focus of this chapter is on the first objective for the review:

The Peer Reviewer will review and assess the feasibility of the Hospital Improvement Plan (HIP) and Implementation Plan developed in March 2012 that would see Health Sciences North (HSN) achieve a balanced budget by September 30, 2012.

The Health Science North HIP includes a number of initiatives with targeted savings for each initiative. The Review Team assessed the organization's progress on each of the initiatives and summary comments are provided in the following two exhibits.

Exhibit 3: HIP Initiatives Contribution to Savings

Mitigation Strategy	Target Improvement Plan	Updated Forecast of Improvement Plan	Amounts Achieved in Fiscal 2011/12	Amounts to be Achieved Fiscal 2012/13
Operational Deficit (Margin)	\$ (8,241,000)	\$ (8,241,000)	\$ (8,241,000)	\$ (8,241,000)
Potential funding Shortfall 2012/13 (HBAM Allocation vs Inflation)	(1,700,000)	(1,700,000)	(1,700,000)	(1,700,000)
Total Operational Deficit 2011/12/13	\$ (9,941,000)	\$ (9,941,000)	\$ (9,941,000)	\$ (9,941,000)
Ongoing Savings Initiatives				
Revenue Generation- Preferred Accommodation	\$ 1,300,000	\$ 1,300,000	\$ 100,000	\$ 1,200,000
Program Efficiencies- Wait Time Volumes	2,100,000	2,100,000	2,100,000	
Program Efficiencies- Mental Health Paeds Volumes	310,000	155,000		155,000
Utilization Management- Critical Care Program Improvements	1,000,000	1,000,000		1,000,000
Utilization Management- Surgical Program Improvements	1,600,000	1,600,000		1,600,000
Utilization Management- Facilities/ Food Services Program Improvements	1,000,000	1,000,000	100,000	900,000
Admin & Support- Restructure Research	1,650,000	1,650,000		1,650,000
Revenue Generation- Teaching Adjustment	880,000	-	-	-
Revenue Generation- Teaching Adjustment- ICU beds	1,500,000	-	-	-
Revenue Generation- New Funding Formula- Dialysis	1,000,000	-	-	-
Total Permanent Savings Initiatives	\$ 12,340,000	\$ 8,805,000	\$ 2,300,000	\$ 6,505,000
One time reductions				
Admin and Support- Parking	\$ 1,100,000	\$ 1,100,000	\$ 1,100,000	\$ 1,100,000
Total Hospital Improvement Plan Initiatives	\$ 13,440,000	\$ 9,905,000	\$ 3,400,000	\$ 7,605,000

Exhibit 4: HIP Initiatives Update Summary July 2012

Mitigation Strategies	Peer Review Comments – July 2012 Results
Ongoing Savings Initiatives	
Revenue Generation – Preferred Accommodation	As of July 2012, Preferred Accommodation is ahead of budget by \$64k. The favorable results can be attributed to an increase in co-payment by \$180k and an under performance in Preferred Accommodation of \$116K, netting \$64k favorable.
Program Efficiencies – Wait Time Volumes	As of July 2012, wait times have been achieved in Cataracts and Orthopedic Primary Hips. Wait times have not been achieved YTD in Primary Knee's (-64) and Orthopedic Revisions (-7). Primary and Revisions and Cataracts were the three wait time categories mentioned in the HIP. Reduction was due mainly to the uncertainty in confirmation of wait time volumes under the new funding formula. Confirmation of volumes from MOH only occurred in July 2012.
Program Efficiencies – Mental Health Pediatric Volumes	The Mental Health budget is on target YTD July 2012. The HIP strategy included a transfer of funding from North Bay for pediatric patients. To date, HSN has not had to trigger an overcapacity scenario with respect to pediatric Mental Health volumes so has not seen the financial pressure yet, therefore has had no impact on HIP.
Utilization Management – Critical Care Program Improvements	July 2012 YTD, the Critical Care Program is net \$350K under budget. HIP targets are built into the budget so HSN is well on its way to achieving this objective.
Utilization Management – Surgical Program Improvements	As of July 2012, the Surgery Program is over budget by \$1.804M. The HIP savings of \$1.2M is built into budget. To date, this objective has not been met. Over budget status is attributed to an increase in volumes in many services but primarily due to Vascular, Thoracic and Neurosurgery. Wait time volumes have not been achieved in Orthopedics and there has been an over performance in many of the other services. HSN is aware of this issue and is working on bringing volumes back to target.
Utilization Management – Facilities/Food Services Program Improvements	The HIP for Food Services is \$750K. This has been built into the budget for 2012/2013. July 2012 YTD, Food Services are over budget by \$190k. The Corporate Service portfolio is showing a slight surplus absorbing the negative performance in Food Services. It is believed the increased cost is related to food cost and would need to be examined more closely
Admin and Support – Restructure Research	The transfer of cost to a separate Research Structure has occurred.
Revenue Generation – Teaching Adjustments	There has an omission on behalf of the MOH in the funding to HSN since 2006. This HIP objective is a retro one time payment and an adjustment to the base of \$880k. The NE LHIN has indicated the retro funding will not be received from the MOHLTC.
Revenue Generation - Teaching Adjustment – ICU Beds	There has been an omission on behalf of the Critical Care Secretariat since 2007/2008 where new ICU beds were not funded at the teaching amount. There has been no reconciliation of this HIP objective.
Revenue Generation – New Funding Formula – Dialysis	This item is still under discussion and had not been resolved. However, there have been recent discussions where the discrepancy has been recognized.
One Time Reductions	
Adm and Support – Parking	Additional Parking Revenues of \$1.1M have not been budgeted and are positioned as one time contingency. July YTD 2012 figures show Parking Revenue above target by \$201k.

The status of each of the HIP initiatives is discussed briefly in the sections following.

Preferred Accommodation
Status: Achieved

This initiative involved rate changes made effective December 2011 and extensive consultations with clinical operations regarding process. As of July 2012, the Preferred Accommodation is ahead of budget by \$64,000. Most of this, however, is attributable to increased co-payment revenues as opposed to any increase in preferred accommodation revenues. Co-Payment rates have changed and an additional change in the co-payment amount is planned for December 2012. The favorable results can be attributed to an increase in co-payments of \$180k and an under performance of Preferred Accommodation of \$116k, netting \$64k positive variance.

Wait Times
Status: Achievable

HSN met and exceeded wait time for the past two fiscal years. The new HBAM and QBP formula would move the Wait Time volumes into the base for 2012/13. Reduction was due mainly to the uncertainty in confirmation of wait time volumes under the new funding formula. As of July 2012, wait times targets have been achieved in Cataract and Orthopedic Primary Hips. Wait time targets have not been achieved YTD in Primary Knees (-64) and Orthopedic Revisions (-7). Primary and Revisions and Cataracts were the three wait time categories mentioned in the HIP where a contribution margin had been assigned to the budget savings. Confirmation of volumes from MOHLTC just occurred in July 2012.

Precision in schedule for wait time must occur between now and year end. Special focus on Orthopedics is necessary in order to achieve wait time targets and generate the volumes to have the necessary excess to contribute to the HIP.

Recommendation

It is recommended that

- (6) The Senior VP/COO of HSN develop specific plans for achieving wait time targets in both Primary Knee Replacements and TJR revisions.**

Mental Health Status: Not
At Risk

This HIP strategy involved a transfer of funding from North Bay for Pediatric mental health patients. HSN currently operates 2 pediatric mental health beds at the Kirkwood Site and budget is on target July 2012 YTD. To date HSN has not had to trigger an overcapacity scenario with respect to MH volumes so has not seen the financial pressure yet, and therefore there has been no impact on the HIP. Should these volumes materialize, there has been no transfer of dollars to pay for these services.

Critical Care
Status: Achievable

This initiative involves clinical program reductions which were initiated in April 2012. July 2012 YTD, the Critical Care program is net \$350k under budget. HIP targets are built into the budget so they are well on their way to achieving this objective.

Surgical Services
Status: At Risk

This initiative involves clinical program reductions which were scheduled to start in April 2012. As of July 2012, the surgery program is over budget by \$1.804M. The HIP savings of \$1.2M is built into the budget. To date this objective has not been met. The variance is attributed to an increase in volume in many services but primarily due to unplanned volumes in Vascular, Thoracic and Neurosurgery. Wait time volumes have not been achieved in Orthopedics and there has been an over performance in many of the other services.

This HIP objective will need special attention for the remainder of the year. The volumes in Surgery will need to be monitored and managed with great discipline to ensure that planned volumes are not exceeded. Planned closures at Christmas and March Break will be required to get back on budget. The Sullivan Group has been engaged to review costs in this program. The hospital should aggressively pursue potential savings in these areas.

Recommendations

It is recommended that

- (7) The Senior VP/COO of HSN establish a more disciplined process to monitor and manage surgical volumes to ensure activity does not exceed budgeted baseline.**
- (8) The VP Clinical Programs/CNE and the VP Medical and Academic of HSN to ensure implementation of planned closures of surgical services at the Christmas Break and March Break.**

Food Services
Status: At Risk

The HIP target for Food Services is \$750k. This has been built into the budget for 2012/2013. July YTD, Food Services is showing a \$190K deficit. The Corporate Services portfolio is showing a slight surplus absorbing the negative performance in Food Services. It is believed that the excess costs are related to unplanned increases in food costs.

Food Services is benchmarking above the worst quartile performance of its peer hospitals. It is recommended that an external review of this service be completed to help understand the cost structure and where costs can be reduced.

Recommendation

It is recommended that

- (9) **The HSN Senior VP/COO undertake an external review of Food Services functions with a goal of reducing costs without reducing quality for patients and visitors.**

Research Infrastructure

Status: Achieved

This initiative was focused on the transfer of costs to a separate Research entity effective April 1, 2012 and this has occurred.

Teaching Revenue

Status: At Risk

The hospital perceives that it has not been receiving teaching revenues that are due from the MOHLTC since 2006. This HIP objective is a retroactive one-time payment and an adjustment to the base of \$880k. However, the NE LHIN has confirmed that the funding adjustment has been received by HSN and no further adjustments are forthcoming.

Similarly, the hospital perceives that it has not received adequate funding for new ICU beds as the Critical Care Secretariat has not funded the new beds at the teaching hospital rate. To date, there has been no acknowledgment of the underfunding or any indication from the MOHLTC that additional funds and funding would be provided to the hospital. The LHIN and HSN should work together to pursue closure of these issues.

Revenue Generation – New funding formula – Dialysis

Status: At Risk

The new funding formula for Dialysis for In-centre/Satellite funding will be implemented 2012/13 and 2013/14. HSN presented to the Ontario Renal Network (ORN) on August 27, 2012 requesting a \$1M adjustment to the HBAM Top Up formula, \$450K for satellite funding and up to \$250K for satellite host hospital funding. This action item is still under discussion and has not been resolved. There have, however, been recent discussions with MOHLTC/Ontario Renal Network where the error has been recognized.

Recommendations

It is recommended that

- (10) **The Senior VP/COO of HSN clarify and resolve the issues with respect to underfunding of Dialysis services provided by the hospital.**
- (11) **The CEO of HSN and the CEO of NE LHIN clarify and resolve the issues with respect to underfunding of the Critical Care beds.**

Revenue – Parking
Status: Achieved

HSN is tracking behind the goal of a balanced budget for September 2012

Additional Parking revenues were not budgeted but rather have been positioned as a contingency to cover any shortages in HIP initiatives or other cost pressures. July YTD figures show Parking above target by \$201k.

The HIP plan initiatives and targets for increased revenues and reduced costs have been built into the 2012/13 budget. Therefore, it would be expected to see a balanced position in the first quarter to indicate that HSN is on track to achieve budget. However, for the period ending July 31, 2012, HSN is showing a \$686,000 deficit (revenue net expenses) from hospital operations. After accounting for depreciation, the hospital's deficit position is \$1.333M. This equates to a 0.52% deficit (hospital operations before depreciation).

The following table provides the sources of both negative and positive variance to budget that are contributing to the deficit position.

Exhibit 5: Budget Variance at July 31, 2012

Sources of negative variance	\$ 000s
Overrun for the Memorial beds	557
Hospitalists	242
WSIB NEER surcharge	356
Program generated Income	59
Drug costs	297
Surgical Program Costs	1820
Sources of positive variance	\$ 000s
Parking	201
Preferred Accommodation	64
Deferred Revenues	2400
Other	208

With greater efforts and greater discipline, HSN will achieve a balanced operating position for 2012/13

Overall, these contribute to the July 31 2012 deficit of \$686k. At this point, HSN is tracking behind the goal of a balanced budget for September 2012. However, with greater efforts and greater discipline, HSN will achieve its HIP targets and a balanced operating position for 2012/13.

Because of the new NEER surcharge, there is an additional pressure that will need to be accommodated in this budget year. As identified, HSN will need to approach the final 3 quarters with greater discipline to achieve its HIP targets and compensate for the new cost pressure.

*The hospital needs more
focus on realization of its
savings opportunities*

The reviewers have found that the hospital possesses the tools necessary to identify cost saving and revenue enhancement opportunities:

- HSN has a sophisticated benchmarking process and track those areas performing above and below the 25th, 50th and 75th percentile. They have systematically been looking at areas that are significantly over target and reviewing opportunity for savings.
- HSN has also been tracking revenues closely and have been lobbying for teaching funds, PCOB and HBAM funding that the hospital perceives to have been omitted in past allocations. There is a significant rigor in the financial planning of HSN which would suggest that these funds may be owed. The LHIN and HSN need to work with the MOHLTC to resolve the remaining revenue issues in order to confirm receipt of revenue necessary for the hospital to balance and/or to identify the quantum of additional savings that will be required from operations.

HSN has a sophisticated decision support team and budget team who are tasked with the data analysis. There is sufficient capability at HSN to identify opportunities for cost savings and/or revenue enhancements. The hospital will need to focus on execution of the various initiatives and realization of the savings/revenues opportunities.

Recommendation

It is recommended

- (12) The HSN CEO, with support from the VP of Finance, develop a more disciplined HIP monitoring process that will ensure a balanced budget at year end.**

7.0 Post Construction Operating Plan and Ambulatory Clinics

This chapter focuses on the following two objectives:

The Peer Reviewer will review HSN's Post Construction Operating Plan (PCOP) reconciliation to determine impact on operations.

The Peer Reviewer will review and assess the feasibility of the business case for the Sudbury Outpatient Clinic.

HSN should receive additional funding contained within PCOP

The reviewer believes that HSN has a very valid position for receipt of the additional \$5.715M contained within the PCOP. The remaining future request for \$35.4M will need to be assessed in the context of the original functional plan for the project. The adjustment that HSN has made to PCOP allocation appears appropriate based on the 2 year operation of the facility.

Recommendation

It is recommended that

(13) The NE LHIN CEO continue to endorse HSN to receive the \$5.715M in the HSN PCOP funding request.

7.1 Ramsey Site Ambulatory Plans

A high-level review of the HSN Ramsey Site Ambulatory Program plans was completed by the reviewers and it was noted that a long list of specialty outpatient clinics were included in these plans. A compelling business case was not provided for the growth and expansion of the identified clinics.

Assessment of ambulatory clinics required

The reviewers did visit the existing Ambulatory Clinics located on the first floor of the HSN. The reviewers' observations were that much of the activity seemed to be what would normally be found in a physician's office practice and it was not clear as to why the hospital would be funding the operating costs of these clinics. It may be the case that some of the activity is appropriately based in hospital Ambulatory Clinics, but an assessment should be undertaken to ensure that the hospital is not inappropriately paying the cost of activity that is normally overhead costs that should be assumed by practicing physicians.

Recommendations

It is recommended that with established timelines

- (14) The HSN Senior VP/COO and VP Medical and Academic undertake a review of the intended purpose of the Ambulatory Clinics operated on the first floor of HSN to ensure the hospital is only undertaking activity that appropriately belongs in the hospital.
- (15) The HSN Senior VP/COO and VP Medical and Academic establish a process to develop a complete business case for each of the Ambulatory/Outpatient Clinics listed within the PCOP.
- (16) The HSN Senior VP/COO and VP Medical and Academic establish a process to prioritize the requested Ambulatory/Outpatient Clinics on a need basis.

7.2 Memorial Site Ambulatory Plans

In 1996/1997, the Health Services Restructuring Commission (HSRC) issued its Directives for the Sudbury community including the future use of Regent (Memorial) Site. Specifically the Directive provided the following:

“The new Sudbury Regional Hospital Corporation will be directed to develop and implement plans to close the Paris and Regent Sites and transfer all hospital programs located on those sites to the Ramsey Site no later than March 31, 1999. A plan to decommission the two sites will be developed and submitted to the Ministry of Health and to the Health Services Restructuring Commission.”¹

It is important to note that this Directive was issued at a time when the consolidation of all services to the Ramsey Site would provide capacity for 560 beds and an expansion of approximately 700,000 square feet.²

HSN Capital Project

Since the issuance of the HSRC Directive, HSN has increased revenues from \$162M in Fiscal 97/98 to \$421M in Fiscal 2011/12. As well, the number of employees has increased from approximately

¹ Page 63 of September 1996 Sudbury Health Services Restructuring Report

² Page 45 of September 1996 Sudbury Health Services Restructuring Report

2,000 FTE in Fiscal 97/98 to 2,935 FTE's in Fiscal 2011/12. In addition, a number of significant changes occurred since the HSRC Directives including (but not limited to):

- Operational Review by the MOHLTC in 2002
- Appointment of Supervisor by the MOHLTC in 2002
- Plan for Redevelopment and Recovery Plan in 2003
- Transfer of Regional Cancer Program from CCO in 2004
- Transfer of 44 Mental Health Beds from NEMHC at Kirkwood Site in 2007
- Transfer of all community district Mental Health services from NEMHC to HSN
- Divestment of 32 Complex Continuing Care Beds to SJCCC in 2009
- Completion of the Capital Project in 2010
- Consolidation of Acute Care Services at Ramsey Site in 2010
- Opening of 136 Interim ALC Beds at Memorial Site in 2010
- Planning Grant Approval for Medical Learner Space in 2010

The revised Capital Project resulted in a reduced acute care bed complement of 429 at the HSN Ramsey Site and a decreased capital expansion footprint of 550,000 square feet. The Paris (SJHC) Site of 380,000 square feet was closed in 2010. In 2008, it was apparent that there would be significant space capacity issues at the Ramsey Site and that consolidation of all hospital services could not safely be achieved. This issue was heightened as the number of ALC patients occupying acute care beds at HSN was at its highest level and continuing to increase.

HSN evaluated two strategies. The first was to move non-critical administrative departments either offsite or to the Memorial Site. The second was to work with the NE LHIN to provide temporary funding for ALC patients at the Memorial Site until capacity in the Sudbury community could be increased (through Assisted Living or expansion of CCAC services) and reduce the number of ALC patients occupying an acute care bed at HSN. As part of their strategic discussions with HSN in 2010/2011, the NE LHIN agreed to fund 60 beds in 2011/2012 and 30 beds in 2012/2013.

7.2.1 Current Situation

Since the consolidation to the Ramsey Site in fiscal 2010/11, HSN has required the continued use of the Memorial Site to accommodate clinical and administrative programs for which there is not adequate space at the Ramsey Site.

Overall the total Gross Square footage available is 185,000 square feet. The available usable net square footage in the Memorial Site is 138,900. Today, programs in the Memorial appear to occupy the entire 138,900 available space.

The 30 ALC beds currently occupy approximately 37,300 square feet. They are slated to close in the fiscal 2012/2013 year.

7.2.2 Operations

The Memorial Site currently accommodates 84,000 square feet of programs that either could not be accommodated at the Ramsey Site or have been net new since the HSRC commission directions to close the facility. At market rate, it is estimated that it would cost \$2.5M in rental expense to accommodate these programs offsite.

The overall facility costs of operating the Memorial Site is \$1.636M. A total of \$1.390M of that \$1.636M is supported from the HSN global budget. In a future state, this would continue to be an allocation from the HSN global to continue to operate that Site. This should be compared against the potential future cost of rental for the programs that have required space either since the 2010 move into the Ramsey Site or are new since the HSRC directions. The business case would suggest that it would be less expensive to continue to occupy those programs at the Memorial Site than it would to rent off site space ($\$2.5 - \$1.39 = \$1.11\text{M}$ savings).

7.2.3 Capital

The hospital has already been anticipating capital upgrades for the site. They plan on allocating \$500k per year to capital upgrades but are not planning any major capital projects on the site.

7.2.4 Programs

Future programs at the Memorial Site would include the following:

- Chronic Disease
 - a) Complex Diabetes Care
 - b) Diabetes Self Management Program

- c) Bariatric Surgery
- d) Chronic Pain
- e) Chiropody
- f) Diabetes Education
- g) Geriatric Day Hospital
- h) Ophthalmology
- i) Ambulatory Clinics
- Screening
 - a) Breast Screening and Breast Health
 - b) Regional Genetics Program
- Education/Research
 - a) Simulation Lab – Clinical Teaching
 - b) Phase 1 Clinical Trials (Contingency Bed Unit)
 - c) Training Room – Computer
- Support
 - a) Finance (Accounting)
 - b) Finance (Business Operations)
 - c) HR
 - d) Volunteers
 - e) Building Services
 - f) Housekeeping
 - g) Materials Management
- External Partnerships
 - a) NE LHIN Satellite Office
 - b) NE CCAC Wound Care
 - c) Physician Rental Offices
 - d) Pediatrics
 - e) Family Practice Unit
 - f) Internal Medicine Unit

This plan would have the full building occupied. The clinical programming for Memorial Site is consistent with the industry direction and would be appropriate. Whether there is available space

at the Ramsey Site is beyond the scope of this review but this would appear to be the case.

Overall the projected Operating Budget for the Memorial Site is \$13,605,927.

Recommendations

It is recommended that

- (17) The HSN CEO and VP Medical and Academic keep the Memorial Site open as an outpatient site until a review of the future ambulatory volumes has been completed.**
- (18) The HSN CEO and VP Medical and Academic ensure any new growth in ambulatory services be subject to review and business case development.**

8.0 Long Term Financial Plan

This chapter focuses on the following element of the terms of reference:

The Peer Reviewer will assess the long term financial plan that will enable Health Sciences North to maintain an operating surplus in future years and entitle them to receive working funds assistance funding.

Hospitals are inherently challenged in their long-term financial planning efforts given funding reforms and policy amendments are an expected and frequent reality in healthcare. These challenges are overlaid with inevitable demographic changes along with constant shifts in priorities that hospitals must respond and adjust to. There is evidence that HSN is anticipating costs and planning beyond the current and next fiscal year as best able given these challenges and HSN also has a strong financial team that is working hard to position long-term viability.

The requirement to develop and operationalize a successful financial plan is, however, not just the responsibility of the CFO. The CEO needs to ensure that processes exist that commit the entire executive to collective ownership and accountability for both short, and ultimately long-term planning needs of HSN.

There is a fiduciary imperative for HSN to achieve a balanced budget.

Equally imperative in the development of a shared financial planning process is an explicit expectation to achieve a balanced budget. It is the opinion of the reviewer that the fiduciary and legislative imperative for HSN to achieve a balanced budget each year needs to be more explicitly stated by the Board of Directors. All members of the executive should have a significant portion of their at risk compensation tied to achieving a balanced budget.

Recommendations

It is recommended that

- (19) The HSN Board of Directors reinforce their expectation that the hospital achieve a balanced operating budget each year.**
- (20) The HSN CEO establish a financial accountability process that reflects the shared responsibilities of the executive and management team to achieve a balanced budget.**

9.0 Long Term Capital Plan

The focus of this chapter is on the following objective:

The Peer Reviewer will review the long term capital and program plans of HSN to ensure alignment with Ontario's Action Plan for Health Care, the priorities of the NE LHIN and reflects population needs.

A longer term, 25 year Capital Plan is nearing completion

The reviewer was advised that a 25 year longer term Capital Plan was nearing completion and being finalized for submission in October or November to the NE LHIN. The reviewer was not provided with anything other than a preliminary Strategic Plan for the hospital.

Over the last few years, the organization has been focused on developing new operating systems within a new facility, along with bringing three different cultures from legacy organizations together onto one site. It is recognized that these significant activities have consumed the hospital over the course of the last decade; it is now appropriate that the hospital proceed with developing its Strategic Plan as an AHSC.

HSN should now proceed with developing its Strategic Plan as an AHSC

The reviewer agrees that this Strategic Plan needs to be in total alignment with Ontario's Action Plan for Health Care and the priorities of the NE LHIN and reflect the population needs. The Strategic Plan should outline the priority goals of HSN for the next 10 years and that a strategy map and balanced score card be used to ensure the hospital's progress towards the plan implementation.

Recommendations

It is recommended that

- (21) The HSN Board of Directors to oversee development of a Strategic Plan that will outline the priority goals of HSN for the next 10 years.**
- (22) The HSN CEO ensure that the strategic planning process is inclusive and consultative and that it be fully aligned with Ontario's Action Plan for Health Care and the priorities of the NE LHIN.**

10.0 Relationship of HSN with Partners and Stakeholders

The focus of this chapter is on the following objective:

The Peer Reviewer will review the relationship between HSN and its stakeholders – internally, in terms of alignment between the administration, the Board, physicians and staff and externally, between the North East Local Health Integration Network (NE LHIN), NE CCAC, St. Joseph’s Continuing Care Centre and the community sector as well as other hospitals in the NE LHIN.

The Reviewers found the HSN team to be an experienced collegial group of health care leaders that operate with a high sense of loyalty and commitment to their organization. It is recognized that HSN has experienced turnover of their President and Chief Executive Officer several times over the past decade which can cause morale issues and uncertainty amongst team members. This, however, did not appear to be the case and team members appeared to be very engaged and committed.

Lack of collective ownership of issues and strategies

The reviewers were most surprised at the lack of shared ownership and collaboration amongst the system’s organizations with regard to the very difficult ALC issue facing HSN. It was common to hear comments such as “if only they would do their job, this issue would be resolved or this issue is not our problem”. It is very apparent that the lack of collective ownership for the ALC issue has meant that executing the actions needed to reduce the ALC rate has not achieved the level of success that might be expected and that should have been achieved.

Every organization in the system plays an important role in the delivery of services to patients in the region. The role of the LHIN is to plan, integrate, and fund services in the communities while the hospital, CCAC, and SJCCC are focused on operations and the delivery of care and services. It is incumbent on the providers to work as a system with the LHIN and collaborate and align skills, services and expertise in efforts to identify the innovative strategies that are required to address the ALC challenges. The legislative improvement imperative for the entire system - NE LHIN, NE CCAC, SJCCC and HSN – is reflected in their respective accountability agreements and achievement of the 2012/2013 ALC target of 17% will require greater collaboration, communication and planning than currently exists.

*HSN ALC Rate to be
10% or less by 2015*

ALC is clearly a health system issue and every partner in the system has a role and an obligation in taking on the challenge. Going forward, it should be made very clear by the Boards of all four organizations that it is their expectation that their respective CEOs determine a way to work effectively with the other three CEOs within Sudbury to determine the best strategies that can be put in place to deal with the very serious ALC issue at HSN. The large number of beds devoted to ALC patients is seriously affecting access to and the quality of care at HSN. This is an issue that must be owned collectively by HSN, by the CCAC, by SJCCC and by the NE LHIN. The four CEOs should be asked to identify progressive six month targets that will effectively reduce the ALC rate at HSN to below 10% by March 31, 2015. The CEOs should be collectively held accountable for the achievement of this goal.

*Need for HSN to take a
leadership role*

Each of the four organizations should designate a senior leader to be part of a leadership team assigned the task of identifying strategies and priorities to deal with the level of ALC patients at HSN. This group should produce monthly performance reports, highlight successes and failures of the actions they have taken. Each of these individuals should serve as the champion within their own organization to push the envelope on delivering positive actions to reduce the level of ALC at HSN.

The reviewers found that in spite of the fact that HSN has significantly more financial and human resources than any other health provider organizations in the NE LHIN, the leadership of HSN has not taken on a leadership role within the LHIN that is required. It should be incumbent upon the President and CEO of HSN along with the hospital's senior leadership team to reach out to other health provider organizations in the LHIN to explore opportunities for higher levels of collaboration and integration to create a stronger health care delivery system for the residents of North Eastern Ontario. The Board of Directors of HSN should have this as an expectation for their CEO and leadership team and the leadership team should be held accountable to demonstrate specific examples of where they have exercised this leadership.

Recommendations

It is recommended that

- (23) The HSN, SJCCC and NE CCAC CEO's designate a senior leader to be part of a leadership team assigned the task of identifying and implementing strategies and priorities to deal with the level of ALC patients at HSN.**

- (24) The Board of Directors of HSN establish an annual goal whereby their executives are required to demonstrate specific examples of how they have exercised leadership at the NE LHIN or sub-LHIN level.**

11.0 Patient Flow

The focus of this chapter is on the two objectives related to the Emergency Department and patient flow:

The Peer Reviewer will review the Emergency Department (ED) Process Improvement Project (PIP) to determine if all recommendations have been implemented and sustained. (Example: access to after hour diagnostics). A special focus on the patient flow and admission process for Mental Health patients will be conducted.

The Peer Reviewer will identify possible strategies that could be implemented to improve the flow of patients in the hospital. This includes a review of bed utilization, integrated discharge planning and physician discharge practices.

*Provincial priority to reduce
ED wait times and ALC
volumes*

In 2007, the Premier of Ontario announced that reducing Emergency Department wait times was a top priority for the government. In 2008, the government announced a comprehensive \$109M strategy (Ontario's ED/ALC Strategy) resulting in the identification and implementation of an array of provincial, LHIN and local improvement strategies and campaigns. In 2012, five years after the Premier's announcement, reducing ED wait times and ALC volumes remain a provincial priority. Despite considerable investment, effort and change there is still significant improvement needed relative to the ALC rate and the ED LOS of admitted patient in many hospitals including HSN.

The details associated with HSN's ED and ALC performance as discussed in this section can be found in Appendix C.

11.1 HSN ED and ALC Performance

The four key ED LOS indicators reported to the MOHLTC by HSN include:

- 90th percentile time to physician initial assessment (PIA)
- 90th percentile ED LOS for all CTAS 1, 2 & 3 non-admitted patients
- 90th percentile ED LOS for all CTAS 4 & 5 non-admitted patients
- 90th percentile ED LOS for all admitted patients

HSN has shown improvement in 3 of 4 indicators

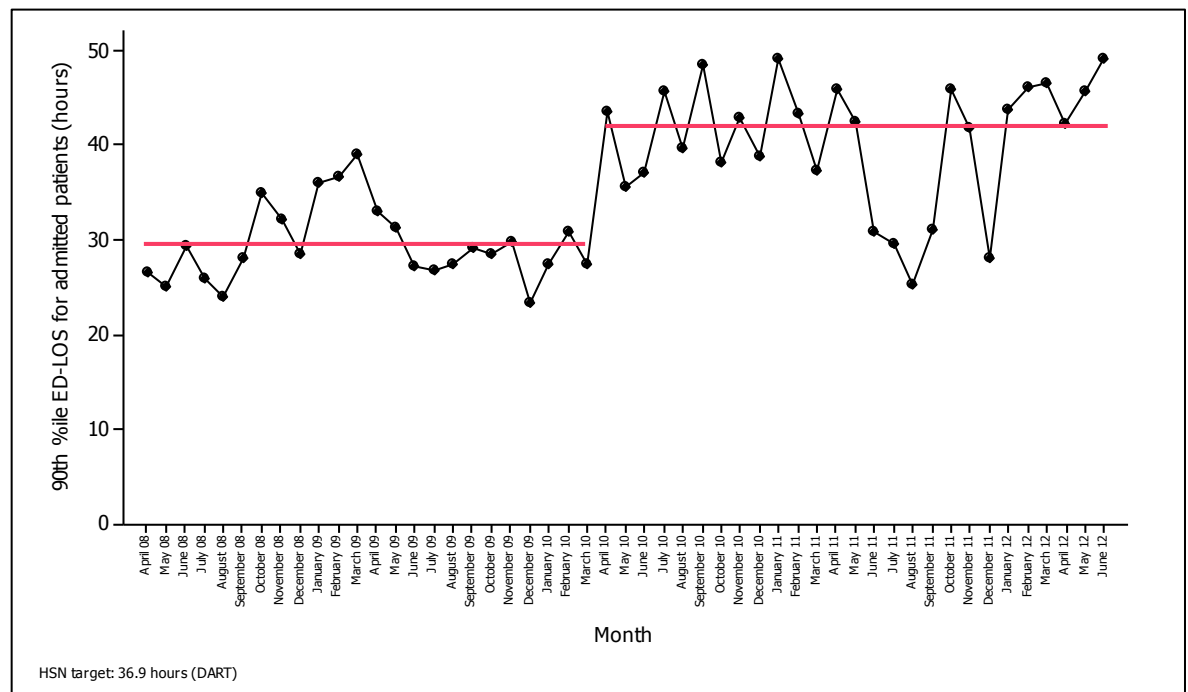
HSN's performance on ED-LOS for admitted patients is the highest of all teaching hospitals

Of the four key indicators, HSN has seen improvement in three in the last 9 months (September 2011 to June 2012). Performance YTD June 12/13 is significantly improved over historical performance for high acuity and low acuity non-admitted patients with wait times near target for both. Except for early 2012, PIA times have also improved in past 9 months.

However, HSN has not improved performance in ED LOS for admitted patients. HSN's ED LOS performance for admitted patients is significantly higher than the average performance of all Ontario's hospitals and is the highest over the last two fiscal years for all teaching hospitals (Exhibit 21).

The wait times for admitted patients deteriorated significantly beginning in April 2010 with an increase in the 90th percentile ED LOS from 30 hours to 42 hours. During the summer of 2011 there was an improvement in this indicator and the 90th percentile ED LOS admitted patient LOS was returned to 30 hours. Performance YTD June 12/13 has deteriorated and 90th percentile ED LOS for admitted patients is now more than 40 hours.

Exhibit 6: HSN 90th percentile ED-LOS Performance for all Admitted Patients (April 2008 – June 2012)

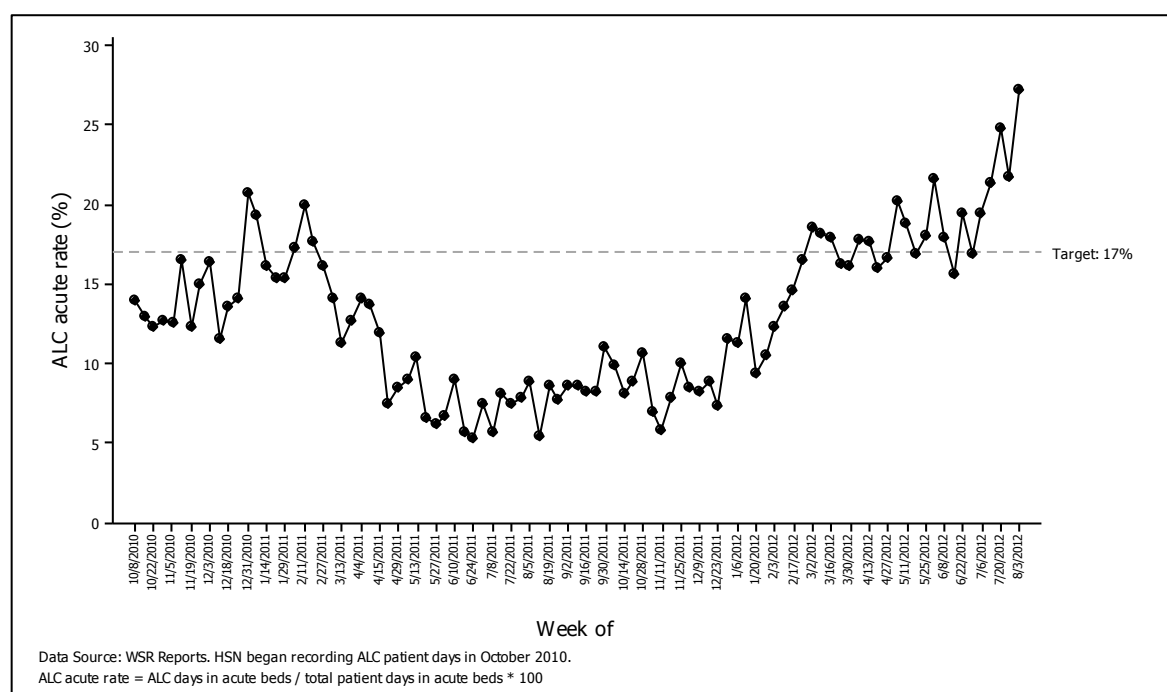


ALC rate is well above target

In the past 2 years the ALC rate at HSN has ranged from 5% to over 25%. A steady increase since early 2012 is noted and the current rate of 25% is well above the 17% target. HSN stakeholders are anticipating a further increase upon closure of the remaining 30 Memorial Site ALC beds in March 2013.

Exhibit 7:

HSN ALC Acute Rate



HSN ED and ALC Performance Improvement

In the past several years HSN has implemented numerous improvement initiatives focused on ED and ALC improvements. Some of the initiatives were HSN specific while others were aligned with the provincial ED/ALC Strategy including the ED Process Improvement Program (ED PIP).

HSN participated in Wave 4 of ED-PIP

HSN was one of 55 provincial hospitals that participated in ED PIP. The program was designed to support improvements in hospital flow and build capabilities within hospitals for long term sustainable change. ED PIP was rolled-out across Ontario from March 2009 to December 2011 through four eight month implementation cycles, known as “waves”. HSN participated in Wave 4 of ED PIP from May 2011 through December 2011.

ED PIP utilized a lean improvement approach to review the flow of patients from arrival in ED through discharge from hospital. In partnership with an expert improvement coach, hospitals were to

identify and implement a series of projects to achieve the following program aims:

- Move performance metrics towards P4R identified targets
- Build organizational capacity to implement change
- Increase patient and public satisfaction with services
- Improve the working environment for staff

HSN identified 25 improvement initiatives in 3 areas of focus

In alignment with the identified goals, HSN identified 25 ED PIP improvement initiatives focused on 3 areas of improvement:

- Emergency Department
- Bed Allocation & Patient Flow
- 4 North Medical Unit

The summary of the status of all initiatives in these 3 areas of focus can be found in Appendix C.

Majority of PIP initiatives implemented and sustained

HSN implemented 22 of the 25 (88%) ED PIP initiatives. Of the 3 initiatives not implemented, HSN continues to re-assess on a regular basis recognizing that 2 initiatives, “Up-front Decision-makers” and a “Clinical Decision Unit”, are large in scope and require a substantial investment of resources. Both initiatives would have been extremely difficult/ impossible for HSN to implement in the timeframe of ED-PIP.

Of the 22 implemented initiatives, 21/22 (95%) have been fully sustained. The only improvement initiative that has not been fully sustained is a “Process Improvement Board” although contrary to staff feedback there is evidence of uptake.

Notable focus on “continuous quality improvement” at HSN

There is a notable focus on “continuous quality improvement” at HSN. Stakeholders attribute the enhanced, but not new, focus on improvement at HSN to ED PIP. Many front-line staff are able to identify what improvements were made, how processes changed and how patient flow has improved as a result of the changes made during (and after) ED PIP. Most impressive is that multiple staff across areas spoke the same *language of improvement* months after ED PIP concluded.

Additional improvement activity and spread is noteworthy

HSN has also implemented many more improvements since the conclusion of ED PIP and spread some of the improvements to other inpatient units. Considering HSN is only 8 months post-ED PIP, the amount of additional improvement work and spread is noteworthy.

Improved ED performance in 3 of 4 metrics

Implementation of ED PIP improvement initiatives resulted in improvements in 3 of the 4 ED wait time measures either during and/or after the conclusion of the program. As noted earlier, with the exception of a few months in early 2012, improvement in non-admitted patient wait times and PIA have been achieved in the last 9 months (September 2011 to June 2012). Improved performance for non-admitted patient appears to correspond to the implementation of specific ED-PIP initiatives including:

- The “See-and-Treat” area,
- “Cardiac Observation” area, and
- “Acute Observation” area

Admitted patient ED LOS did improve slightly during the summer of 2011 but the improvement was not sustained. Stakeholders attribute the temporary improvement primarily to the opening of 128 new LTC beds at St. Gabriel’s Villa.

11.2 ED Admitted Patient Length of Stay

ALC volumes perceived to be primary cause of admitted patient waits

ALC volumes are perceived by most HSN stakeholders to be the primary cause of admitted patient wait times. As illustrated in Exhibit 8, the common perception is that long wait times for admitted patients are *caused by* too many admitted patients in the ED waiting for an inpatient bed which in turn is *caused by* too many ALC patients in inpatient beds.

Exhibit 8:

ED Admitted LOS Cause and Effect

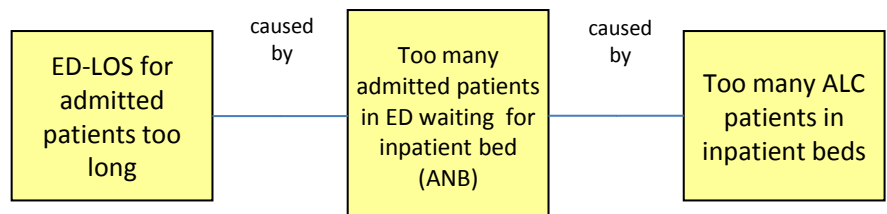


Exhibit 9 confirms that there is a strong positive correlation between the number of ANB in the ED at 0700 and the ED LOS for admitted patients as measured at the 90th percentile. In fact, this relationship is statistically significant ($p < 0.01$) and ANB volumes explain approximately 82% of the variability seen in the ED LOS for admitted patients.

Exhibit 9:

**Correlation between ANB and ED-LOS for
Admitted Patients**

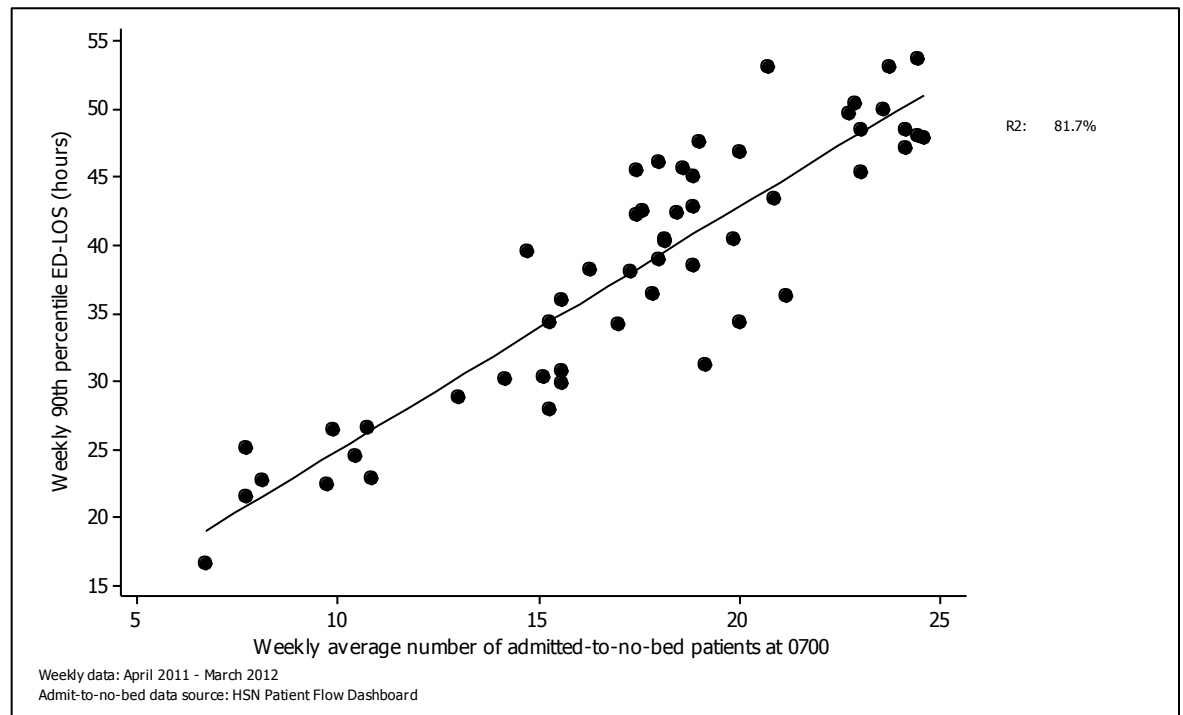
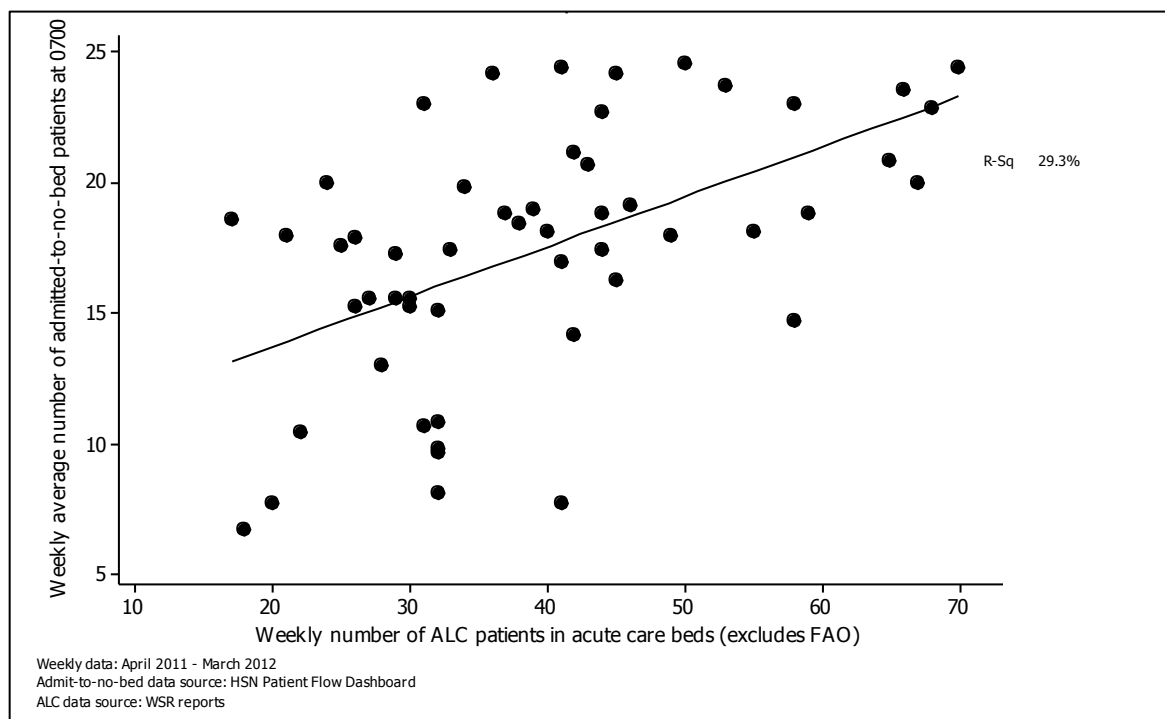


Exhibit 10 demonstrates that although there is a positive correlation between the number of ALC patients and the number of ANB in the ED at 0700, this correlation is much weaker. This relationship is statistically significant ($p < 0.05$) but the number of ALC patients explains only approximately 29% of the variability seen in the number of ANB patients.

Exhibit 10: Correlation between Number of ALC Patients and Number of ANB



ALC unquestionably a major challenge

While ALC is not the single contributor to ANB volumes at HSN, it is unquestionably a major challenge. Improvement to the current 25% rate and achievement of the 17% target requires strategies to reduce the number of patients designated ALC and/or a reduction in the days associated with ALC. However, concurrent exploration of the many other variables that may contribute to ANB volumes is critical given 70% of the variability in ANB volumes is not directly associated with ALC volumes.

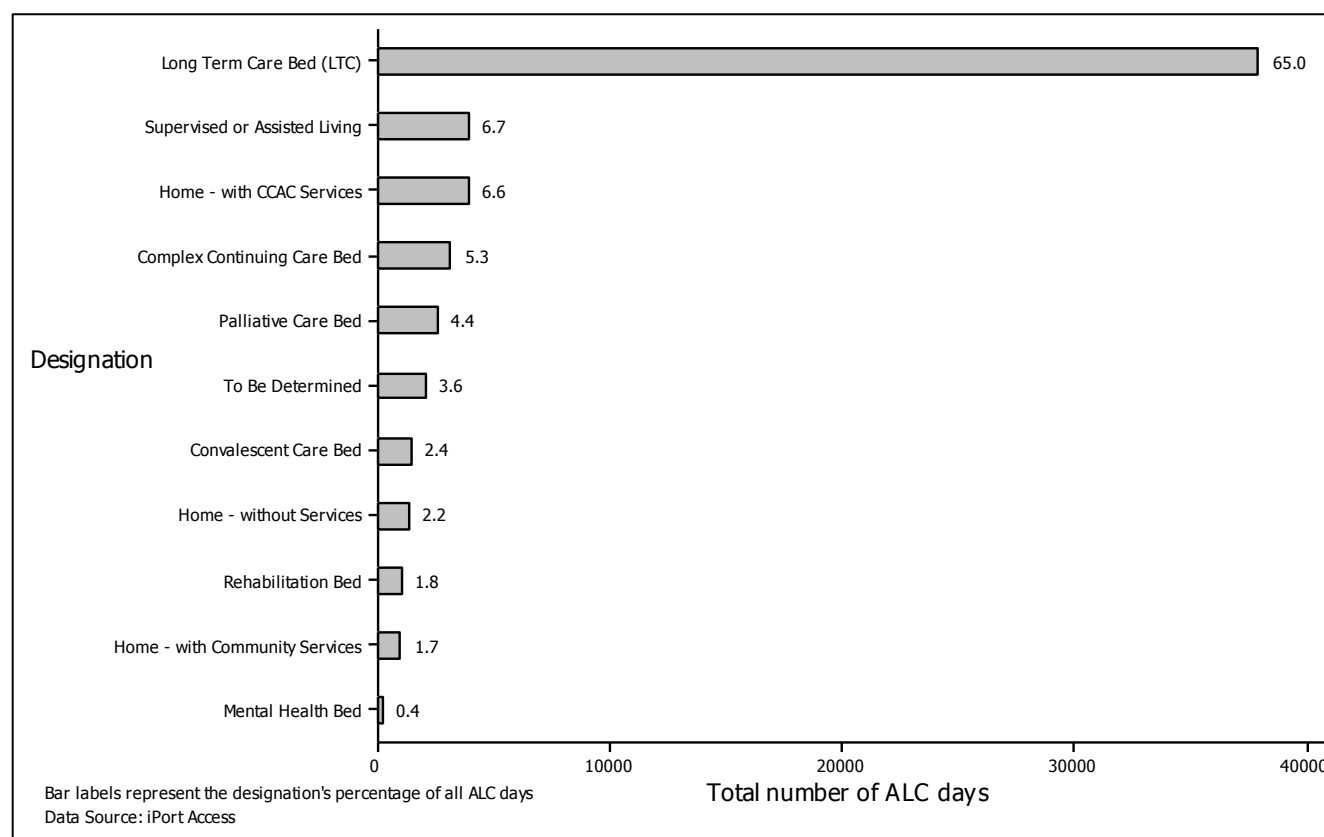
11.3 ALC Management

Similar to many other Ontario hospitals, the most common ALC designation for HSN is LTC with almost two-thirds of HSN's ALC days (closed cases) attributed to ALC LTC. Given this, the ALC rate will be influenced by strategies that will:

1. Reduce the number of ALC-LTC days
2. Reduce the number of new ALC-LTC designations

Exhibit 11:

**ALC Days by Designation of Discharge Destination (closed cases)
(April 2011 – June 2012)**



1. Reducing ALC Days

Need to reduce ALC days associated with LTC designation and determination

Waits for long-term care beds can be extensive and vary according to LTC home. The NE LHIN is identified as having the highest number of LTC beds when compared to other LHIN's yet the hospital waits at HSN are still long as a result of the existing demands (wait lists) on LTC homes and rates of new LTC designations.

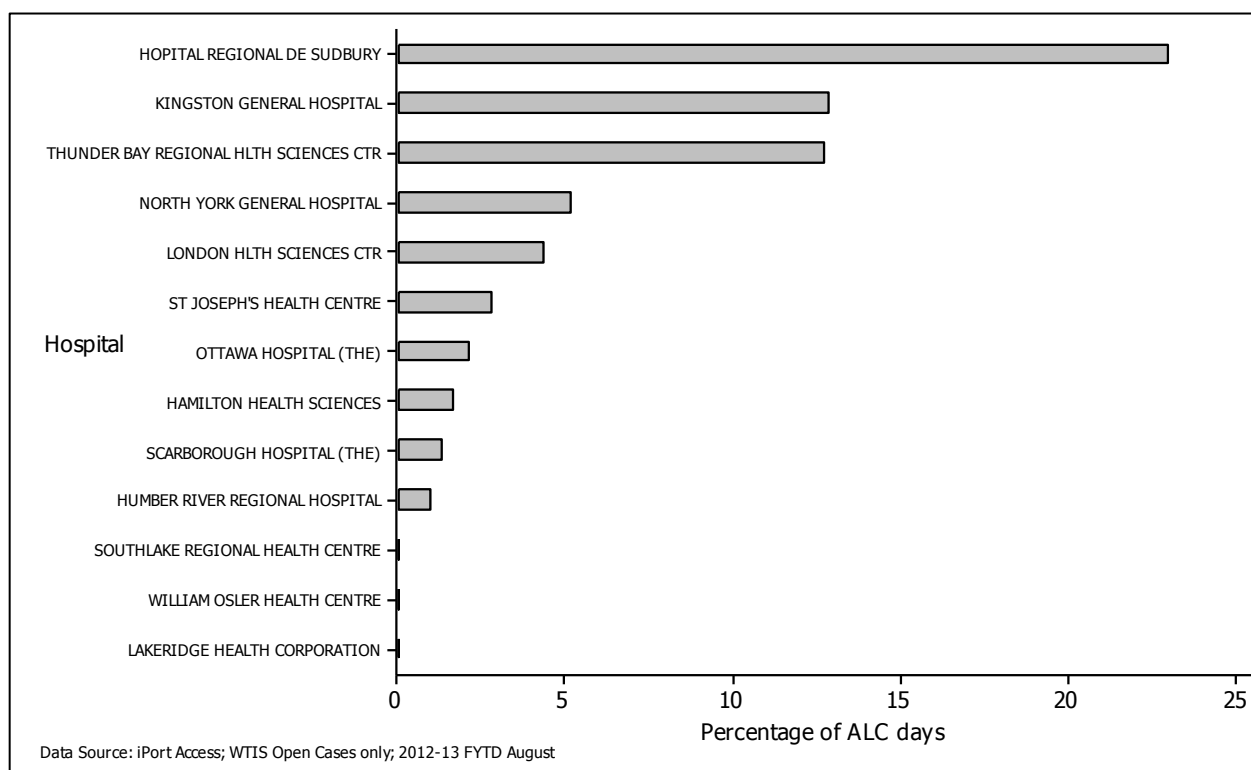
Given waits for LTC beds are not anticipated to change quickly in the relative future, hospitals must ensure that every opportunity to reduce days associated with the ALC designation and determination processes are identified. Lack of proactive management of the process can result in the accrual of considerable days and ultimately lengthen an already very long LOS for patients waiting LTC beds.

HSN has higher proportion of TBD days

In an analysis of open cases at similar teaching (or very high volume community) hospitals, HSN has a significantly higher proportion of ALC "To be determined (TBD)" days. In fact, the proportion of

ALC-TBD days for open cases at HSN is two to five times higher than comparable organizations.

Exhibit 12: Percentage of ALC days as TBD (open cases only)
(Similar sized Community & Teaching Hospitals)



Need to identify anticipated destination

Wait Time Improvement Strategy (WTIS) Guidelines³ suggest that when clinical teams are working with patients towards a specific discharge destination, patients should be designated ALC to that destination (ALC-LTC-TBD, ALC-CPP-TBD, etc.) rather than ALC –TBD while waiting for eligibility to be determined. This process of designation allows for:

- greater collective clarity and awareness of the patient's discharge plan;
- monitoring for improvement opportunities related to delays; and
- appropriate recovery of co-payment for patients waiting ALC-LTC or ALC-CCC.

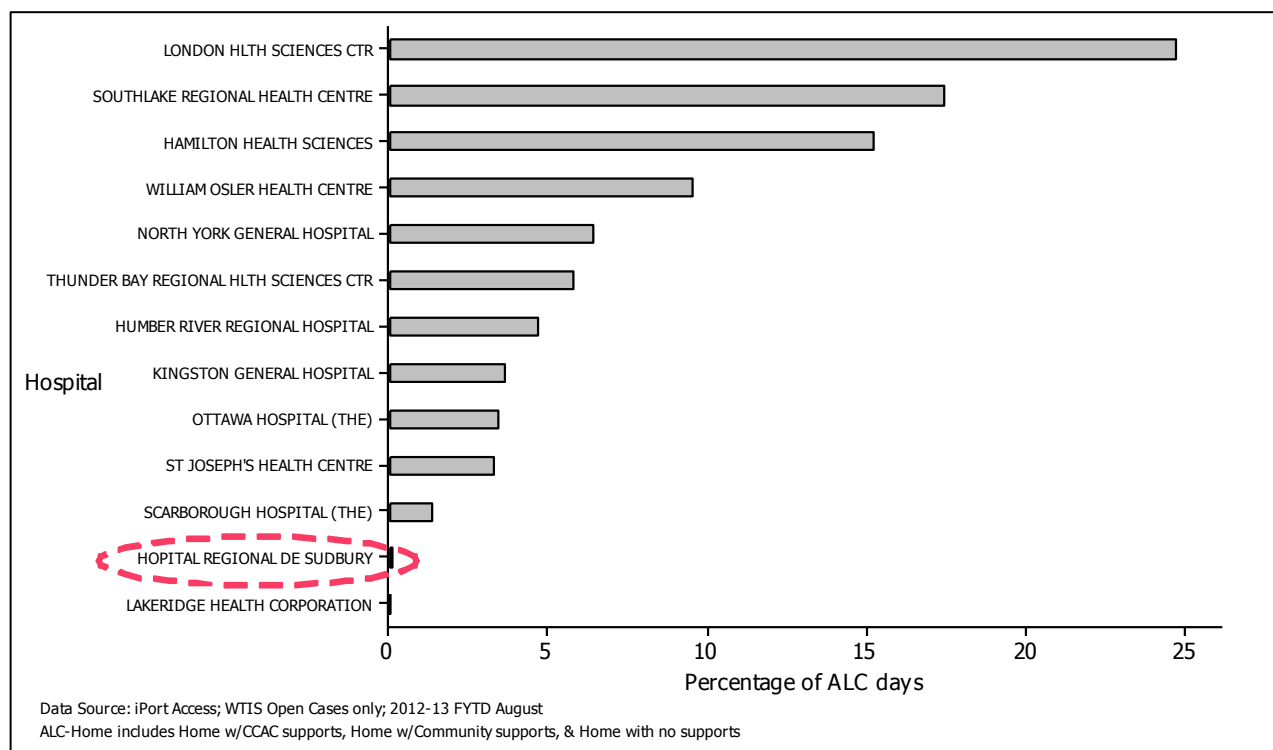
³ Wait Time Improvement Strategy Guidelines, Appendix 1, Cancer Care Ontario

HSN has very low number of cases designated ALC-Home

The ALC-TBD designation should only be used on a temporary basis in circumstances when a discharge destination is not immediately known.

A similar analysis of patient days, demonstrates that HSN has less than 1% of their open cases designated ALC-Home, significantly lower than other teaching hospitals, as illustrated in the following exhibit.

Exhibit 13: Percentage of ALC Days with Discharge destination "Home" (Similar sized Community & Teaching Hospitals)



Capturing ALC-Home is also part of WTIS recommendations and accurate identification of ALC-Home days provides focus when identifying opportunities for improvement. There was varying opinion among HSN stakeholders as to whether there were delays. Anecdotal information provided suggests there are, at minimum, some inherent delays in the process for discharging patients to home.

Arguably, increased reporting of ALC-Home days may further worsen the ALC rate for HSN, but the alternative is potential under reporting of ALC days and missed opportunity to identify areas of improvement as related to discharges home, be they delays/barriers related to the hospital, CCAC and/or other partners. It is also worthy of exploring why other hospitals accrue more ALC-Home

days. It is possible that the days maybe a reflection of the degree to which supports for Home First are in place to support discharges home or the degree to which clinicians choose Home as an option for discharge.

Recommendations

It is recommended that

- (25) The HSN VP Clinical Programs/CNE establish a process to align ALC designation practices related to “To Be Determined” with WTIS guidelines.
- (26) The HSN VP Clinical Programs/CNE implement a process to ensure patients are appropriately designated “ALC Home” as per WTIS guidelines.

2. Reducing ALC New Designation

Average 5 new ALC LTC Patients per week

HSN currently designates an average of almost 5 patients per week ALC-LTC, with as few as 1 new designation per week and as many as 10(see Exhibit 22 in Appendix C).

There is not a provincial target or benchmark for new LTC designations, although an increasing number of LHIN’s and hospitals in Ontario have introduced targets along with formalized processes that include executive leadership approval of all ALC LTC designations (Escalation). The introduction of targets and Escalation processes reinforce and demonstrate a philosophy of shared accountability and ownership for ALC performance and are identified as essential processes for those organizations who are successfully managing ALC.

Need to develop Escalation process

In August 2011, the provincial ALC Action Team recommended the NE LHIN establish a standardized “Escalation” process for applicable hospitals. It was further suggested that agreement was required with respect to the number of ALC-LTC designations to be made in hospital. To date, there is not an Escalation process or new ALC-LTC designation target for NE LHIN hospitals. Development of an Escalation process is, however, identified in the “Regional Integrated Discharge Planning (IDP) Working Group” work plan.

Recommendations

It is recommended that

- (27) The NE LHIN Senior Director ED and ALC prioritize development and implementation of a standardized Escalation process for NE LHIN hospitals.
- (28) The CEO HSN assign accountability and oversight of HSN Escalation process to the Senior VP/COO or VP Clinical Programs/CNE.
- (29) The NE LHIN Senior Director ED and ALC, in collaboration with HSN and the NE CCAC, establish a weekly target for “New ALC-LTC Designations”.

Effective management of ALC, inclusive of all designations, requires a robust infrastructure of support ranging from technical tools to overarching philosophy’s of care. HSN’s model of ALC management includes the essential elements but there is opportunity for the collective provider group to enhance and expand in areas including Home First and the Integrated Discharge Planning model.

11.3.1 Home First and Home to Wait

Home First is an evidence-based, person-centred, transition management philosophy focused

The LHIN’s and hospitals in Ontario that are demonstrating improvements in ALC and reductions in new ALC designations credit success to the implementation of Home First and supporting strategies. Home First was originally introduced in Ontario by the Mississauga Halton LHIN in 2008 and introduced in the NE LHIN in August of 2010.

Home First is an evidence-based, person-centred, transition management philosophy focused on:

- Supporting patients to return home on discharge from hospital prior to assessment for and/or admission to a Long Term Care home or other care setting
- Keeping patients, specifically high needs seniors, safe in their homes for as long as possible with community supports
- Ensuring long-term care is considered only after all other community alternatives have been explored

Pervasive skepticism at HSN about availability of community infrastructure and resources

Undoubtedly, Home First requires a fundamental shift in practice and mindset of health care providers. There is a considerable range of opinion at HSN as to what constitutes Home First and varied responses to the question “*Has HSN adopted the Home First philosophy?*” There is also a pervasive skepticism among HSN staff and physicians with respect to the availability of community infrastructure and resources. Physician stakeholders particularly emphasized concerns regarding the responsiveness of community

HR issue impacting ability to implement

partners to both inpatient and outpatient referrals. They identified opportunities to expedite discharges/prevent admissions given the expansion of community programming.

Additional concerns were raised by physicians and various HSN and CCAC stakeholders relative to the ability of service providers to fulfill (let alone expand) service agreements due to human resource issues associated with recruitment and retention of Personal Support Worker staff. It was identified that previous review(s) had identified issues related to inadequate compensation, transportation and rural working conditions but to date strategies to address these issues remain outstanding.

Practices at HSN do not align with Home First

There is evidence of practices within HSN that do not align with Home First including the designation of patients in the ED as well as disparity in the messaging provided to patients and families regarding the program. The lack of a 24 hour/7 day per week (24/7) “Home to Wait” program was commonly cited as one of the primary deficits of Home First in the NE LHIN. “Home to Wait” programs support hospital discharge with appropriate supports while planning and waiting for transition to long term care. In some LHIN’s enhanced services including 24/7 supports are routinely provided for a select number and type of patients. ALC-LTC designations have been substantially reduced in hospitals that are supported by these robust “Home to Wait” programs. The reviewer noted that Hamilton Health Sciences improvement from 12 new designations per week to the current average of 3, was, in part, due to the introduction of a 24/7 “Home to Wait” program.

In August 2011, the ALC Action Team identified a number of suggestions as to how to enhance “Home to Stay” and “Home to Wait” programming in the NE LHIN. A review of these suggestions should be prioritized followed by clear communication as to what community supports are available. Currently, there is not a shared understanding as to what service levels are available to HSN patients, and while enhanced service packages are available there is not 24/7 programming akin to what is available in some other hospitals and LHIN’s.

Re-launch Home First Philosophy

There should be a commitment to re-launch the Home First philosophy which should include the following elements:

- Collective commitment of HSN and CCAC leadership to model and steward shared ownership and accountability for ALC management

- Formal identification of Home First Executive Sponsors for HSN and CCAC
- Review and education of Home First principles with HSN and CCAC stakeholders and physicians
- Re-education of front-line staff and physicians including review of existing CCAC supports and resources
- Review of Home First toolkit to ensure implementation of best practices (i.e. introduction of decision tools including scripts for staff and physicians to support consistent Home First messaging)
- Clear guidelines regarding ALC designation processes including discontinuation of designations in the ED.

Recommendations

It is recommended that

- (30) HSN CEO and NE CCAC CEO fully re-launch Home First philosophy.**
- (31) The NE LHIN Senior Director ED/ALC and NE CCAC CEO establish a review of service provider capacity concerns and update the status of previous review recommendations.**
- (32) The NE LHIN Senior Director ED and ALC and CEO NE CCAC to review all ALC Action Plan strategies related to Home First and determine requirements for implementation of “Home to Wait” 24/7 programming for the NE LHIN.**
- (33) The NE CCAC CEO and Senior Director of Client Services establish a process for a physician stakeholder meeting to identify current service concerns and improvement opportunities, and discuss opportunities for enhanced community programs.**

11.3.2 Integrated Discharge Planning

Successful implementation and sustainment of Home First requires extensive collaboration among the LHIN, hospitals, CCAC, and other community partners and sectors. To support and enhance integration an “Integrated Discharge Planning” (IDP) model was introduced in the NE LHIN in 2010. The model includes designated IDP staff including 2 Directors and 2 Managers for the NE LHIN. A formal evaluation of the program and roles has yet to be completed

but comments and feedback from stakeholders indicates there is reason to initiate.

Concept of IDP well supported

The concept of the IDP model is well supported at all levels of HSN and CCAC and the benefits of having Director and Manager roles is readily identified. There is common thought that a truly “integrated” model is yet to be realized but is expected given the relative newness of the model.

Concern re breadth and scope of Director Role

There is, however, widespread concern regarding the breadth and scope of the Director role given oversight includes HSN, 12 NE LHIN rural hospitals and accountabilities related to the CCAC community referral process. There were stakeholder comments associated with the new IDP model and “impossible” expectations in reference to the current draft work plan for the “Regional IDP Work Group” which identifies 53 improvement initiatives for the NE LHIN. The initiatives range in scope and complexity, some focus on LHIN wide initiatives while others are more regional and/or hospital centric.

Currently there are no Terms of Reference formalizing the scope and accountabilities of the “Regional IDP Work Group”. The group is, however, regularly meeting and actively working through implementation of several LHIN and hospital initiatives. Some of the initiatives including the development of a standardized Escalation process should be reassessed as this may be more appropriately aligned to the NE LHIN ED/ALC Steering Committee.

Oversight of “Regional IDP Work Group” is provided by the “IDP Steering Committee” with membership including hospital Vice Presidents from the 4 HUB hospitals, the Senior Director of Client Services for CCAC and the two Directors of IDP. The IDP Steering Committee has not held regular meetings although a meeting was to be scheduled for September, 2012. Terms of Reference are not available for this group.

Lack of alignment of ALC working groups and committees

The relationship between the respective IDP committees and the NE LHIN ALC/ED committee structures needs to be formalized and clarified for stakeholders. There is currently a NE LHIN ED/ALC Executive Committee and Leadership Committee. Local ED/ALC committees, including a Sudbury ED/ALC committee were established and while some local committees in the NE LHIN continue to meet, Sudbury does not. The NE LHIN is currently reviewing their ED/ALC committee structures which will provide opportunity to ensure alignment and clarity with respect to accountabilities and membership of all the various ED/ALC forums.

*Formal review and
evaluation of IDP model*

There should be a formal review and evaluation of the IDP model and alignment of all similar activities so as to reduce duplication and focus the efforts of all participants. The review should encompass at a minimum:

- Scope and accountabilities of Director role
- Development of Terms of Reference for both Regional IDP Work Group and IDP Steering Committee
- Review and finalization of draft 12/13 IDP work plan. Initiatives to be reviewed and those more appropriate for the NE LHIN ED/ALC Steering Committee should be realigned

Recommendation

It is recommended that

- (34) The NE LHIN Senior Director ED and ALC and the NE CCAC CEO to establish a review and evaluation process for the IDP model and processes.**

*Significant resources at
HSN for ALC/IDP
management*

The resources and infrastructure supporting ALC management at HSN are impressive. An “ALC Office” co-locates CCAC, IDP and Utilization staff and is adjacent to a “Bed Allocation” Office. The shared environment has allowed for enhanced integration of HSN and CCAC staff and creates efficiencies with respect to communication and information sharing. Stakeholders identified relationships between HSN and CCAC as mutually respectful. An ALC database has been developed and provides significant patient-level detail, useful for operational decisions regarding bed utilization, and for monitoring discharge planning processes. Weekly, well attended, ALC Rounds provide a forum for review of all ALC patients including those located at the Memorial Site.

Both the benefit and challenge of the HSN model are the numerous stakeholders involved in discharge planning and ALC management. Utilization staff, Social Work, IDP staff, and CCAC staff are all participants in the process but role delineation and accountabilities are not clear.

*Opportunity to refocus
activity following the
implementation of IDP*

Some stakeholder groups identified the need for greater organizational clarity regarding new lines of accountability, specifically noting the absence of an organizational “launch” of the IDP model. It was noted that the current HSN Discharge policy has not been updated post-implementation of the IDP model to reflect changes in roles, process and accountabilities. There were additional challenges identified with CCAC’s alignment of staff to either

“Acute” Case Managers or “Complex” Case Managers and with stakeholders identifying the need for available “Complex” Case Managers on units with high ALC volumes.

It will be very important for discharge planning and ALC management to update policies and clarify roles and accountabilities for Utilization, Social Work, IDP and CCAC to reduce areas of overlap and duplication.

Recommendations

It is recommended that

- (35) The HSN VP Clinical Programs/CNE to update the discharge policy to include IDP model and realigned roles and accountabilities.**
- (36) The HSN VP Clinical Programs/CNE to clarify current roles and accountabilities for discharge planning and ALC management.**
- (37) The CCAC Senior Director Client Services to review CCAC Case Manager alignment and ensure units with high ALC volumes are assigned a “Complex” Case Manager.**
- (38) The VP Clinical Programs/CNE to re-launch the IDP model corporately following the recommended review and evaluation.**

Best practice for discharge planning processes recommends that discharge planning starts on admission (or before admission for elective patients). While discussions between HSN and CCAC may occur early in the patient's stay, stakeholders indicate formal referrals to CCAC may not be completed until the patient is designated ALC. This practice often leads to plans changing once CCAC becomes actively involved in discharge planning.

Introducing the referral process earlier would allow for enhanced and proactive discharge planning and potentially influence the need for an ALC designation. Furthermore, enhanced collaboration between CCAC and HSN staff throughout the discharge planning process, including joint discharge planning meetings with patients and families, would not only reduce the likelihood of discharge plans changing but ultimately shorten the time it takes to finalize discharge plans.

Formal intensive case reviews should also be implemented for patients at risk of becoming ALC-LTC and included as a requisite component of the Escalation process.

Process for managing bed refusals not commonly understood

The process for managing patient refusals of bed offers from a chosen LTC home is well articulated by HSN leadership and processes to address and escalate have been established. However, front-line stakeholders identify a practice that is different from the process articulated by leadership. There was stakeholder feedback suggesting that the process requires review. Even though the number is not substantial, 1 bed refusal can lead to a significant accrual of ALC days associated with a patient's wait for the next bed offer. A review is required to ensure standardization and proactive management is in place and is operationalized.

Recommendations

It is recommended that

- (39) The CCAC Senior Director for Client Services review the current CCAC referral process to ensure policies align with best practice and support early referral.**
- (40) The CCAC Senior Director for Client Services and HSN VP Clinical Programs/CNE establish a process for intensive case management review for all patients at risk of becoming ALC-LTC and include in the Escalation process.**
- (41) The HSN VP Clinical Programs/CNE ensure bed refusal processes are managed according to corporate policy.**

Placement from Hospital review required

In 1993, with the introduction of the Provincial Placement Coordination System, all tasks related to placement to LTC were to be the responsibility of CCAC with the exception of health and functional assessments. With changes to the Long-Term Care Homes Act in 2010, OCCAC revisited their obligations under the LTCHA and realigned practices across the province with the original intent of the placement coordination process. As such, there was a fairly substantive change for hospital stakeholders in the placement from hospital process. Discussions with HSN staff suggest there would be merit in reviewing the impetus for change and the provincial adoption of the practice to address perceptions that the process is isolated specifically to HSN. Increasing awareness and understanding of the new requirements and the benefits of, may contribute to a greater appreciation of the intent and objectives of the re-alignment particularly in the context of Home First.

There are identifiable gaps in the current placement from hospital processes as related to a lack of *shared* awareness of the patient's status in the process. Discussion in ALC Rounds and Bullet Rounds regarding the status of the RAI, capacity assessment, choice lists and bed offers reflects the need to establish formalized mechanisms to identify and monitor the patients' progress through the placement from hospital process. Given the complexity of hospitals, both HSN and CCAC would be remiss in not establishing a mechanism to monitor the patient's status and ensure all efforts were focused on expediting the processes required to support the placement from hospital.

Recommendation

It is recommended that

(42) The HSN VP Clinical Programs/CNE and CCAC Senior Director Client Services develop a shared "Placement from Hospital" communication tool, identifying the process elements and timelines for completion.

SJCCC key post-acute partner

St. Joseph's Continuing Care Centre (SJCCC) is a key post-acute partner, working closely with HSN and CCAC in the management of patients through the care continuum. SJCCC has 64 beds aligned as follows:

- 32 Medically Complex beds
- 16 Geriatric Rehab beds
- 16 Assess and Restore beds.

Medically Complex beds are noted to be underutilized and frequently used to accommodate overflow Assess and Restore volumes. There are currently 8 ALC LTC patients at SJCCC, all awaiting placement since transfer from HSN in 2009. Unlike HSN, the SJCCC ALC patients have not, to date, been identified for priority crisis placement.

Opportunity to improve community access to CCC beds and prevent ED visits

Intake into CCC beds is coordinated by CCAC who manage referrals and wait lists from both HSN and community. Only approximately 5% of current referrals are from community but there is thought that this number may not reflect demand. Physician stakeholders identified potential opportunity to enhance service response times for community referrals as delays can result in ED visits/admissions. SJCCC stakeholders identified opportunities to explore management strategies that would allow them to review wait lists and assess clients for admission based on clinical need – thus

*Opportunity to improve
communications between
SJCCC and HSN*

ensuring that community patients at risk do not deteriorate/ de-condition to the point of requiring hospitalization and/or placement.

Opportunity to improve communications between SJCCC and HSN was observed. While SJCCC is not a standing member of the LHIN ED/ALC Steering Committee they were included in membership on the local ED/ALC Sudbury Committee – which no longer meets. While there is clearly operational dialogue between the organizations, a leadership forum to identify opportunities to strengthen partnerships, identify and steward system improvements, and advance seniors focused care priorities would be invaluable.

HSN stakeholders identified challenges related to CCC admission “refusals” with concerns primarily focused on a perceived “low threshold” for acuity. CCC stakeholders counter that it relates to the lack of ready access to acute care and the diagnostic services and specialized health professionals that potentially may be required to manage the more acute patients. With a refusal rate of approximately 10%, SJCCC has recently reviewed and expanded admission criteria. A meeting with stakeholders to communicate the changes is forthcoming in the fall.

The opportunity to improve operational processes and communications among CCAC, HSN and SJCCC were observed and validated by stakeholders. Issues related to duplicative assessments, ineffective communication processes and unnecessary delays in patient transfers. There were particular concerns related to patient flow and empty beds at SJCCC despite patients ready for transfer from HSN and full wait lists. Analysis shows that there has been on average 1.0 empty bed daily at CCC for the January 2012 to August 2012 period. However, important to note is these beds may have been booked for an impending transfer versus “vacant”. SJCCC stakeholders did, however, confirm that, on occasion, vacant beds exist. The anecdotes related to excessive CCC empty beds on a regular basis can be disputed in the analysis tables in Appendix C. A process mapping exercise to examine the flow is scheduled in October.

Recommendations

It is recommended that

- (43) The CCAC Senior Director of Client services explore priority status for patients waiting LTC placement at SJCCC to optimize flow across all transition points.**

- (44) The CCAC Senior Director of Client services establish a consultative process including physicians and SJCCC to review community and ED referral processes and identify opportunities as related to delays and assessment processes.**
- (45) The SJCCC VP Clinical Services undertake process mapping of CCC referral processes and develop interim strategies to ensure no transfer delays between facilities.**
- (46) The SJCCC VP Clinical Services review opportunities for CCC to expand Home First supports to HSN including potential care path amendments for frail elderly.**
- (47) The SJCCC VP Clinical Services conduct a six month evaluation of revised Admission Criteria.**

In efforts to address HSN ALC pressures, crisis placement for the hospital was in place until May 2012. When HSN was not eligible for crisis placements (May and June) the number of crisis clients in the community continued to rise. The cause for this increase in-light of the removal of hospital crisis status is unclear but may reflect a random peak in community demand. However, since June 2012, clients awaiting crisis placement in the community has declined while the number of ALC-LTC patients at HSN has continued to increase (See Appendix C). The reviewer noted the immediate imperative to resume priority status with stakeholders during the review process.

*Priority Status for HSN
Required*

The balance between crisis placements from hospital versus from community needs to be closely and carefully monitored by the LHIN. There is collective stakeholder support for community priority for any at risk community patient. In determining the requirement for priority status for hospitals consideration needs to be given to ED wait times, ANB volumes, occupancy rates, surgical cancellation rates, regional refusals and scheduled care deferrals. Monitoring of hospital access metrics and the volume of clients awaiting crisis in the community should be regularly reviewed as part of a monthly assessment of hospital crisis status.

*ALC Rate should be
standard performance
metric for monitoring*

Given the collective monitoring of ALC that occurs across the system it is essential that there is a common metric by which performance is measured. . The ALC “rate” is the standard metric for ALC performance reporting and although HSN does collect the ALC rate for reporting purposes, the preferred indicator for monitoring ALC performance is the “number of ALC patients”. While this is helpful in communicating the impact of ALC on the acute bed capacity, it is less specific and not as helpful for tracking

trends, shifts and sporadic changes in performance. More importantly, it is less sensitive in its ability to detect improvements in ALC.

Recommendations

It is recommended that

- (48) The NE LHIN Senior Director ED/ALC, CCAC CEO and the VP Clinical Programs/CNE immediately meet to review priority status for HSN; develop a formalized process for ongoing review; and identify/implement strategies to strengthen the balance between hospital and community partners.
- (49) The HSN VP Clinical Programs/CNE to include the ALC rate with monthly trending, target, mean and statistical control limits in performance monitoring reports.

*Need for remaining
Memorial Site beds until
ALC recommendations
implemented*

Until the identified ALC recommendations are implemented the reviewers would not recommend closing the remaining 30 Memorial Site beds. An implementation plan inclusive of timelines and measures of success that supports closure of the Memorial Site beds for a date *no later* than September 2013 should be developed and reviewed monthly by the LHIN, HSN, SJCCC and CCAC CEO's. No later than May 2013, a representative leadership group should begin weekly operational planning meetings to ensure timelines for decanting of the Memorial Site are in line with the September 1, 2013 deadline for closure.

Recommendations

It is recommended that

- (50) The HSN CEO continue operations of the 30 ALC beds at Memorial Site until September 1, 2013.
- (51) The CEO NE LHIN consider the continuation of the funding arrangement for the Memorial beds until August 31, 2013.

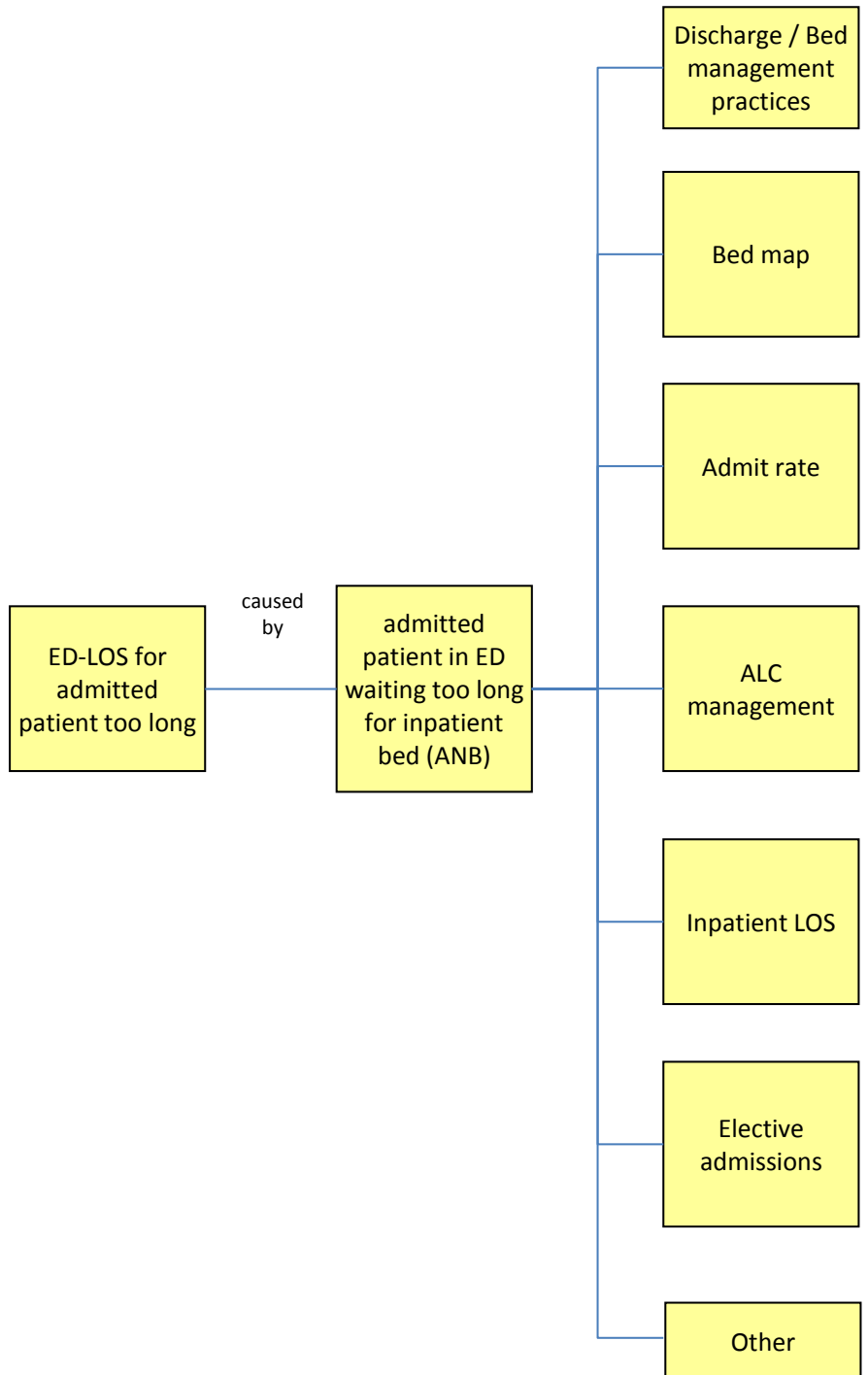
11.3.3 Non-ALC Variables Impacting Patient Flow and ANB Volumes

*70% of the time ALC
is not contributing to
long ED waits*

The requirement to address and resolve the ALC issue is indisputable. There is, however, clear evidence suggesting that there are other variables to be considered given that 70% of the variability in ANB's is not attributable to the variation in the ALC volumes.

As identified in Exhibit 14, the other areas of potential impact include Admit Rate, Elective Volumes, Bed Map, Length of Stay and Discharge/Bed Management processes. The reviewer did not fully explore all of the other variables aside from some of the observations below. It is recognized that HSN may, and probably does, have initiatives underway related to the many variables. Nevertheless, exploring these variables in the context of ANB volumes will be critical.

Exhibit 14: Areas of Potential Impact on ANB



HSN is admitting 13.6% more ED patients than would be expected based on comparisons with the performance of other Ontario hospitals

Admission Rate

The admission rate for HSN in FY11/12 was 17.3% versus the provincial teaching average of 15.2%⁴. Hay Group has also identified *expected* inpatient ED admission rates by patient diagnosis, CTAS, and patient age (based on overall provincial rates). Based on this measure, HSN is admitting 13.6% more ED patients than would be expected. For example:

- HSN admits the second highest percentage of chest pain ED patients. Of all large hospitals in Ontario, HSN admits 14.4% of ED patients presenting with chest pain compared to an expected 7.1% admissions
- HSN admits the second highest percentage of syncope/ dizziness ED patients. Of all large hospitals in Ontario, HSN admits 21.6% of ED patients presenting with syncope compared to an expected 12.7% admissions.

There may be *potential* for HSN to reduce the admission rate based on the above, but more exploration would be required before assuming there is definitive opportunity. Augmenting a review of admissions by visit diagnosis with a review of admissions based on discharge Case Mix Group might yield different findings and areas of opportunity.

Inpatient Average Length of Stay

HSN is committed to realizing LOS opportunities as evidenced by the investment in Medworxx, a recognized utilization management tool that has helped HSN address patient flow barriers and informed improvement initiatives. Despite many gains, there may be further opportunity to reduce LOS and associated patients days.

Some opportunity to reduce LOS at HSN

According to Exhibit 15, LOS at HSN is long when compared to other large Ontario hospitals. For the majority of hospitals, actual LOS (ALOS) performance is lower than 90% of the expected LOS (ELOS) while at HSN actual LOS performance is 95% of expected LOS. The result is an estimated 17 conservable bed day opportunity. Almost 4 conservable beds (at 90% occupancy) are due to acute LOS opportunities in Cardiology. Additional conservable bed day opportunities can be found in Orthopedics and Cardiac Surgery of 2.5 conservable beds each. (See Exhibit 25, Appendix C).

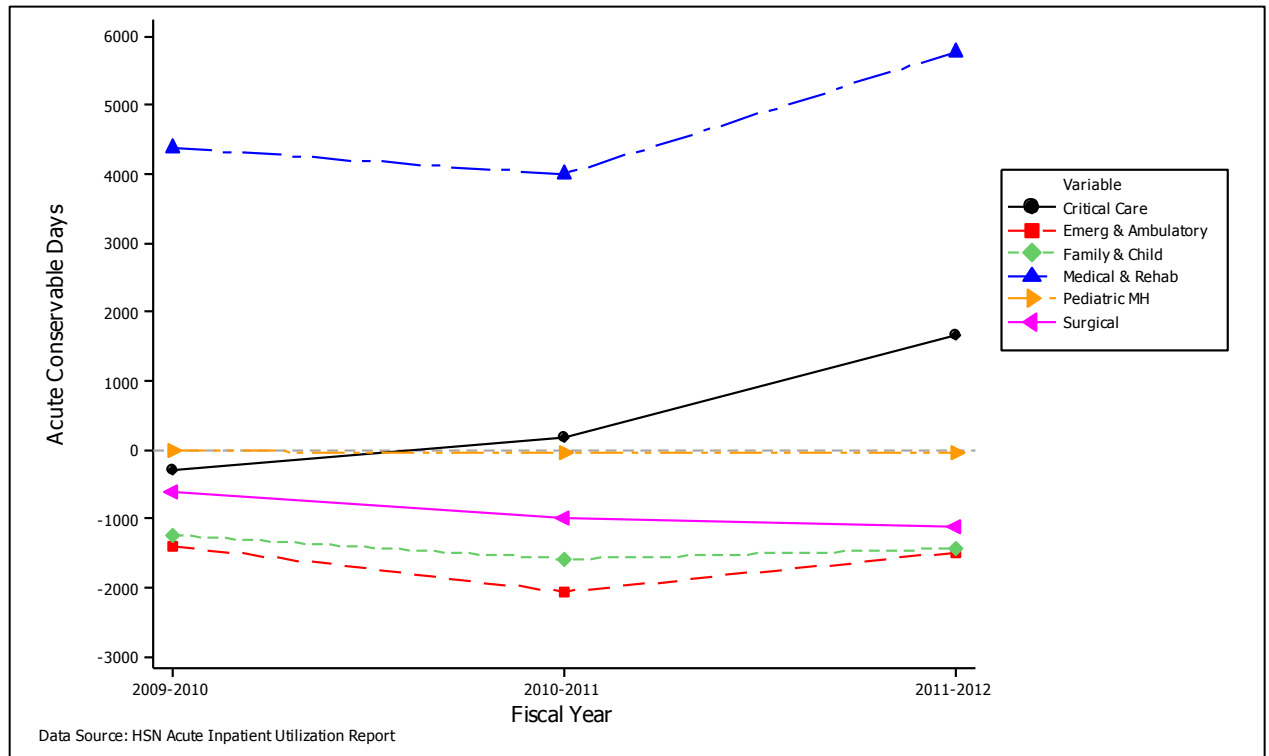
4 CIHI Portal for ED Visits FY 2011/2012

Exhibit 15: LOS Performance of Low Performing Larger Ontario Hospitals (FY10/11)

Hospital	"Typical" Cases	Acute LOS	ELOS	Actual as % of ELOS
Hospital For Sick Children	12,135	4.33	4.21	103.0%
Hopital Montfort	11,480	3.68	3.80	96.9%
Mount Sinai Hospital	23,421	3.71	3.88	95.5%
Health Sciences North	16,593	4.46	4.68	95.4%
Kingston General Hospital	16,697	5.22	5.55	94.2%
Thunder Bay Regional	15,647	5.00	5.31	94.1%
Halton Healthcare	20,387	3.98	4.26	93.5%
Humber River Regional	19,788	4.11	4.43	92.8%
Ottawa Hospital	38,022	4.99	5.39	92.5%
Credit Valley Hospital	20,869	3.67	3.97	92.4%
Rouge Valley HS	19,136	3.68	4.03	91.3%
London Health Sciences	33,816	5.18	5.70	90.9%
Royal Victoria Hospital Barrie	13,976	4.09	4.50	90.8%
Scarborough Hospital	26,620	3.98	4.42	90.1%

While these conservable bed estimates are based on 2010/2011 data, fiscal year 11/12 data from HSN in Exhibit 16 demonstrates LOS opportunities, appreciating the internal methodology of ALOS compared to ELOS is *less* aggressive and more in line with the standard methodology used in hospitals.

Exhibit 16: HSN Conservable Bed Trends



Year to date 12/13 LOS data was not available, but HSN stakeholders indicated to reviewers that LOS opportunities remain and there are further increases in some areas such as Mental Health. As such, HSN has identified plans to introduce Medworxx in the Mental Health program in the fall of 12/13.

Recommendations

It is recommended that

- (52) The HSN VP Clinical Programs/CNE to investigate the cause(s) for increased conservable acute beds in FY 2011/12 in both Medicine & Rehabilitation and Critical Care programs.**
- (53) The HSN VP Clinical Programs/CNE to review 11/12 conservable bed data to determine continued opportunity in Cardiology, Cardiac Surgery and Orthopedics.**

Other ANB Variables

In addition to exploring Admit Rates and LOS opportunities, HSN is strongly encouraged to investigate the remaining variables including

bed allocation (Bed Map), Discharge/Bed Management Planning processes and Elective Admissions:

Consider Predictive Modeling solutions

- **Bed Map:** All hospitals are challenged to identify bed requirements for specific programs/services and most rely on historical utilization, predicted volume/activity targets and intuition to determine alignments. HSN should consider opportunities to further explore Predictive Modeling solutions. While there are no current retail products with the functionality to provide the complex modeling required for hospitals there are prototypes in development and growing expertise in the field. The Centre for Research in Health Care Engineering (CRHE) at the University of Toronto is an internationally recognized leader in the development of predictive models in healthcare and is supporting work and research in a number of Canadian hospitals with demonstrated success.

Increasing scheduled volumes will also impact capacity and ANB volumes

- **Elective Admissions:** Monitoring of elective admissions should include the impact of activity increases on overall hospital multiple areas of program priority should be developed in efforts to ensure there is an appropriate balance of inpatient access provided to all stakeholders including the ED, OR, ICU, and regional partners.

Implement additional “pull” strategies for all HSN services

- **Bed Management/Discharge Planning Processes:** HSN has implemented a number of internal processes to support Bed Management including an impressive Bed Allocation office. Numerous capacity adding strategies have been implemented including the introduction of “Staging” beds. HSN should give consideration to the implementation of additional “pull” strategies that apply to *all* HSN services and programs including a clearly visible and fully operationalized escalation process when ANB thresholds are met. The potential to create additional interim bed locations in addition to the current surge beds should be explored. There should also be further review of the physical footprint of HSN to re-look at opportunities to transition private rooms to semi-private. Further consideration of other temporary locations for admitted patients should also be re-explored including the concept of “express units”. Given the future ability to introduce an ALC cohort unit, a review of staffing models is needed to ensure efficiencies are realized.

11.4 Patient Flow and Mental Health

Complex nature of mental health system impacts patient flow

Patient flow at HSN is impacted by challenges associated with the Mental Health program. As noted above, opportunities have been identified in Mental Health. As part of this review, the Review Team was requested to comment on the MH program.

There are 62 inpatient MH beds supported by HSN:

- 35 inpatient beds at the Ramsey Lake Health Centre (27 inpatient ward and 8 intensive care) and
- 27 inpatient beds at Kirkwood Place (25 adult and 2 pediatric).

Additional Mental Health inpatient bed capacity for the NE LHIN is provided at the North Bay Regional Health Center (NBRHC). In addition, HSN operates numerous outpatient Mental Health and Addictions programs and services that support care and treatment in the community and surrounding areas. There are 31 post-acute MH beds at Kirkwood Place and operated by the NBRHC.

The review team noted the following for the HSN operated Mental Health beds:

- Occupancy below 100% (See Appendix C.)
- 2nd highest number of ANB in the ED are MH patients – 50% of time there is at least 4 ANB patients per day (See Appendix C.)
- Successful implementation of a 4-bed Transitional Discharge Unit (pilot) demonstrated a reduction in readmissions, reduction in MH ED LOS, reduction in in-patient LOS and improved patient satisfaction. It was noted that the pilot was discontinued due to budgetary restraints but would be reassessed given any potential PCOP revenues.
- The complexity and challenges of the NE LHIN MH model were identified by many HSN stakeholders including leadership, physicians and staff.
- Review team believe comments received reflect a less than positive, cooperative and effective relationship between NBRHC and HSN.

Need for a more comprehensive review

The Review Team recognizes the very complex nature of the Mental Health system in the LHIN. There is a need for a more comprehensive review of the shared Mental Health role between

HSN and NBRHC and perhaps eventually a broader review of the NE LHIN model of MH services.

Recommendations

It is recommended that

- (54) The CEO HSN and CEO NBRHC to work collaboratively to develop and implement a more effective structure for managing MH patients between the two organizations.**
- (55) The HSN Senior VP/COO to explore permanent funding to allow for continued implementation of the Transitional Discharge Unit.**

Appendix A: Review Team Resumes

Murray T. Martin ***President & CEO Hamilton Health Sciences***

Murray T. Martin has been President and CEO of Hamilton Health Sciences (HHS) since 2001. He is one of the most respected hospital administrators in Canada with more than 40 years of experience in a number of leadership roles.

At Hamilton Health Sciences, Mr. Martin leads a large teaching hospital organization with five sites and an annual budget of \$1.2 billion. HHS is both a community hospital and a regional referral centre for south central Ontario, serving a population of 2.3 million people.

When Mr. Martin joined HHS, it was just emerging from a period of government-mandated supervision. His strong leadership and unwavering vision have enabled the organization to regain financial and operational stability. At the same time, Mr. Martin's strategic management has advanced Hamilton Health Sciences' reputation as one of Canada's leading healthcare organizations.

Before joining HHS, Mr. Martin held a number of key positions at other hospitals in Canada. He was President of British Columbia's biggest specialty teaching hospital, Vancouver Hospital & Health Sciences Centre, for almost 10 years. He also served as Executive Vice President and Chief Operating Officer of Sunnybrook Medical Centre in Toronto from 1986 to 1991, and before that (from 1975 to 1985), he was Administrator of Pasqua Hospital in Regina, a specialty hospital for patients from across southern Saskatchewan.

Throughout his distinguished career, Mr. Martin has helped to shape and influence the healthcare system by providing leadership on many provincial and national boards such as the Council of Academic Hospitals of Ontario, the Ontario Hospital Association, Accreditation Canada, and HIROC – the Healthcare Insurance Reciprocal of Canada. Mr. Martin was also a member of the federal government's steering committee that created the Canadian Institutes of Health Research (CIHR), a national agency responsible for funding health research in Canada.

At Hamilton Health Sciences, Mr. Martin has been a strong advocate for research and recently, HHS was recognized by a European research ranking agency as the number one health research institution in Canada – number seven worldwide.

Another of Mr. Martin's key contributions has been in patient safety. His commitment has reinforced Hamilton Health Sciences' position as a leader in the patient safety movement, winning multiple provincial and national awards for innovation and quality including two *Sibbald Awards of Excellence & Innovation* and six *Innovation in Healthcare Awards*.

The creation and implementation of a Values-based Code of Conduct for staff and physicians at Hamilton Health Sciences was also led by Mr. Martin. He provided guidance and support for the development and adoption of a philosophy of Patient- and Family-Centred Care, as well as HHS' Patient and Family Code of Conduct.

One of Mr. Martin's most visible achievements has been the revitalization of healthcare infrastructure in Hamilton. From 2007 to 2012, more than \$650 million in construction and renovation took place at Hamilton Health Sciences facilities. The successful funding, planning and construction of these vital projects is due, in large part, to Mr. Martin's vision and leadership. New projects enabled by that funding and now serving Hamilton and surrounding region include the new Juravinski Hospital, the Regional Rehabilitation Facility and the David Braley Cardiac, Vascular and Stroke Research Institute.

Mr. Martin is a graduate of the Health Administration Program at the University of Toronto and holds a Bachelor of Administration degree from the University of Saskatchewan.

Rebecca Repa

President, St. Peter's Hospital & Integrated Vice President Diagnostic Imaging and Laboratory Medicine, St. Joseph's Healthcare Hamilton and Hamilton Health Sciences.

Rebecca Repa began her role as President of St. Peter's Hospital in Hamilton on December 6, 2010. St. Peter's Hospital will be leading the initiative for enhancing the lives of seniors and those with chronic illness.

She began her career at St. Mary's General Hospital in Kitchener in 1994 as the Director of Quality and Risk Management. She subsequently joined McMaster University, Faculty of Health Sciences as the Manager of the Department of Surgery. Prior to her role in hospitals, Rebecca spent a period of time in the private healthcare sector.

Rebecca joined St. Joseph's Healthcare Hamilton in 1994 leading change initiatives with the medical staff and the diagnostic departments. She was responsible for over \$1 billion dollars of capital redevelopment. Rebecca continues to lead initiatives in Laboratory and Diagnostic Imaging for both St. Joseph's Healthcare Hamilton and Hamilton Health Sciences as an Integrated Vice President.

Rebecca is a graduate of the Michael G. DeGroote School of Business, McMaster University where she received her MBA. She received a Bachelor of Arts Degree in Psychology also from McMaster University. Rebecca has served her alma mater as a current member of the Business Advisory Council of the Michael G. DeGroote School of Business and is an Industry Professor and Executive-in-residence for DeGroote as well.

Sharon Pierson

Sharon Pierson is the Director of Quality, Patient Safety and Risk Program at Hamilton Health Sciences. Sharon has worked in health care for 25 years in clinical, educational and administrative roles and has a substantive critical care background. In her current role, Sharon's responsibilities include optimizing patient flow from pre-admission through post acute discharge. She is recognized for her work and interest in operations research and the application of predictive modeling to inform hospital capacity requirements and for her expertise in Staff Scheduling models. Sharon is a member of the Hamilton Niagara Haldimand Brant (HNHB) LHIN ALC/ED Steering Committee and a member of the provincial Excellent Care for All Act (ECFAA) Advisory Group for Hospital Quality Improvement, representing the Council of Academic Hospitals of Ontario (CAHO). Sharon has a Nursing Degree from McMaster University in Hamilton and a Masters in Public Administration from Queens University in Kingston.

Tim Dietrich

Tim Dietrich is the Senior Consultant for Process Improvement within the Quality, Patient Safety and Risk Program at Hamilton Health Sciences. In this role, Tim provides key strategic support and counsel to Hamilton Health Sciences' senior leaders according to areas of focused expertise including analytics, evaluation, project management and process improvement. He has his Bachelor's Degree in Science (Mathematics) from Wilfrid Laurier University and a Master's Degree in Mathematics (Statistics) from the University of Waterloo. His expertise is in the analysis and display of data, lean/six sigma, and quality improvement. Tim is certified by the American Society for Quality as a Six Sigma Black Belt and Quality Engineer, applying his skills on quality and process improvement projects for over 13 years in both manufacturing and health care organizations.

Cherilyn van Berkel

Cherilyn van Berkel is Transitional Care Discharge Specialist at Hamilton Health Sciences, within the Quality, Patient Safety and Risk Program, and has been in this role since 2006. She is also the ALC Clinical Lead at Hamilton Health Sciences since 2010, and is a member of the Provincial ALC Advisory Council of Cancer Care Ontario. Cherilyn was instrumental in implementing the Wait Times Strategy for ALC at Hamilton Health Sciences, one of the Provincial BETA sites. She brings over 15 years of clinical healthcare experience, both in a direct care and systems level capacity. In her current role Cherilyn provides clinical consultation around complex patient transitions, as well as system- level analysis related to patient flow throughout the continuum of care. She is Lean Six Sigma Greenbelt trained, and holds a Bachelor's Degree in Psychology

from McGill University, a Bachelor's and Master's degree in Social Work from McMaster University and is currently a PhD candidate in Social Work at McMaster University. She currently holds a Social Sciences and Humanities Research Council scholarship related to her doctoral research, the focus of which is on understanding the experience of patients from marginalized populations engaged with the healthcare system.

Appendix B: Interviewees

Health Sciences North

- Ann Moro - Surgical Access and Quality Improvement Coordinator, HSN
- Ben Petersen - Chief Financial Officer, HSN
- Chantal Lamothe - Clinical Nurse Reviewer, Utilization, HSN
- Charge Nurse and front-line nurses, 4North, HSN
- Charge nurse and front-line nurses, Emergency Department, HSN
- Crystal Pitfield - Clinical Manager, Emergency, HSN
- David McNeil - Vice President Clinical Services and CNE, HSN
- Debbie Barnard - Director, Quality and Patient Safety, HSN
- Debbie Szymanski - Clinical Program Performance Analyst, HSN
- Dr. Denis-Richard Roy, President and CEO, HSN
- Fatima Al-Roubaiai - Process Improvement Coordinator, HSN
- Grace St. Jean - Assistant Vice-President, Clinical Programs HSN
- In-patient Managers - Social Work, Charge RN staff, HSN
- Jacquelyn Tollerton - ALC Office, Utilization, HSN
- Jayme Watson - Manager CQI Emergency, HSN
- Joe Pilon - Senior Vice President, Chief Operating Officer, HSN
- Julian Lavallee - Clinical Manager, 4North, Medicine, HSN
- Kayla Stevens - Clinical Coordinator, Care Transitions/Virtual Ward Project, HSN
- Laura Green - Clinical Manager, Inpatient Respiratory Care Unit, Medicine, HSN
- Laurie Reed - Social Worker, 4 South, Surgical, HSN
- Lisa Smith - Administrative Director, Emergency & Ambulatory Care, HSN
- Luule Tiisler - Clinical Nurse Reviewer, Utilization, HSN
- Lyne Squires - Clinical Manager Inpatient Mental Health, HSN
- Mark Dowdall - Social Worker, 5 South, Medicine, HSN
- Mary Townend - Manager, Utilization, HSN
- Maureen McLelland - Administrative Director Mental Health & Addictions, HSN
- Medical & Rehab Program, HSN
- Monique Crites - CQI Manager Medicine & Rehab Program, HSN
- Nicole Dowdall - CCAC Case Manager, HSN
- Paul S. George - Director, Finance, HSN
- Russell Boyles - Board Chair, HSN
- Sandra Duhamel - Director, Decision Support & Reporting, HSN
- Shannon Clark - Process Improvement Coordinator, HSN
- Shannon Kenrick - Patient Flow Supervisor, HSN
- Tyler Speck - Administrative Director, Medical Imaging, HSN

Physician Group

- Dr. Chris Bourdon, HSN
- Dr. Paul Gibb, HSN
- Dr. Peter Zalan, HSN
- Dr. Robert Lepage, HSN
- Dr. Sandra Cameron, HSN

NE Community Care Access Centre

- Ann Matte - Senior Director, Strategic Planning and Integration, North East CCAC
- Brent Burton - Chief Financial Officer, North East CCAC
- Frankie Vitone - Senior Director, Client Service, North East CCAC
- Kerby Bechard - Director, Integrated Discharge Services, North East CCAC
- Richard Joly - Chief Executive Officer, North East CCAC
- Rob Barnett - Director of Strategic Planning and Integration, North East CCAC

NE St. Joseph's Complex Continuing Care

- Barb Desjardins – VP Corporate Services, St. Joseph's Health Centre
- Cathy Tait - Social Worker, St. Joseph's Continuing Care Centre
- Christine Cote – CCAC Case Manager, St. Joseph's Continuing Care Centre
- Colette Plourde - Director of Care, St. Joseph's Continuing Care Centre
- Jo-Anne Palkovits – Chief Executive Officer, St. Joseph's Continuing Care Centre
- Josee Cholette – Admissions Coordinator, St. Joseph's Health Centre
- Kari Gervais - Vice President of Clinical Services, St. Joseph's Health Centre
- Lianne Valiquette – Vice President of Planning and Support Services, St. Joseph's Health Centre
- Lynda Powell– Physiotherapist, St. Joseph's Continuing Care Centre

North East – Local Health Integrated Network

- Louise Paquette - Chief Executive Officer, LHIN
- Martha Auchinleck - Senior Director, Performance & Decision Support, LHIN
- Terry Tilliczek - Senior Director, Emergency Department/Alternative Level of Care, LHIN

Appendix C: Patient Flow and ALC Exhibits

Exhibit 17:

HSN 90th percentile ED-LOS Performance for all Admitted Patients
(April 2008 – June 2012)

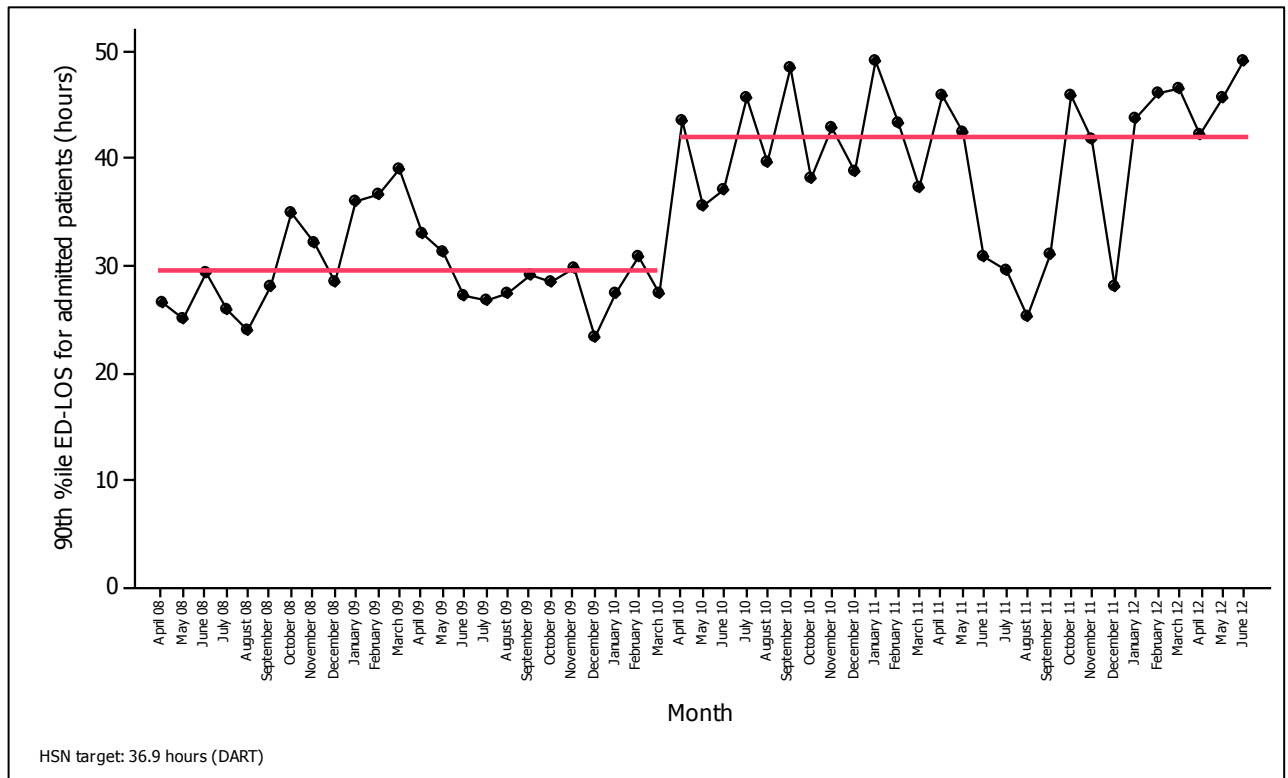


Exhibit 18:

90th percentile ED-LOS for all CTAS 1, 2, & 3 non-admitted patients
(April 2008 – June 2012)

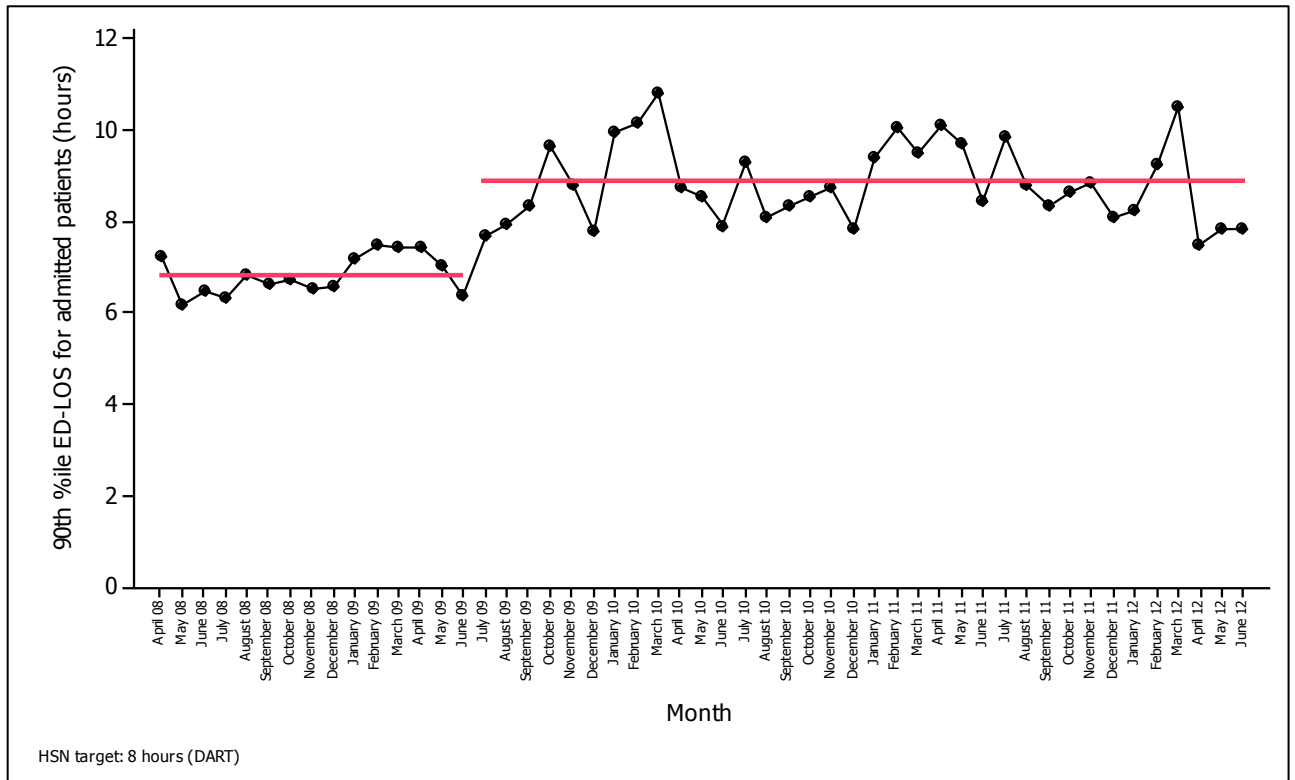


Exhibit 19:

90th percentile ED-LOS for all CTAS 4 & 5 non-admitted patients
(April 2008 – June 2012)

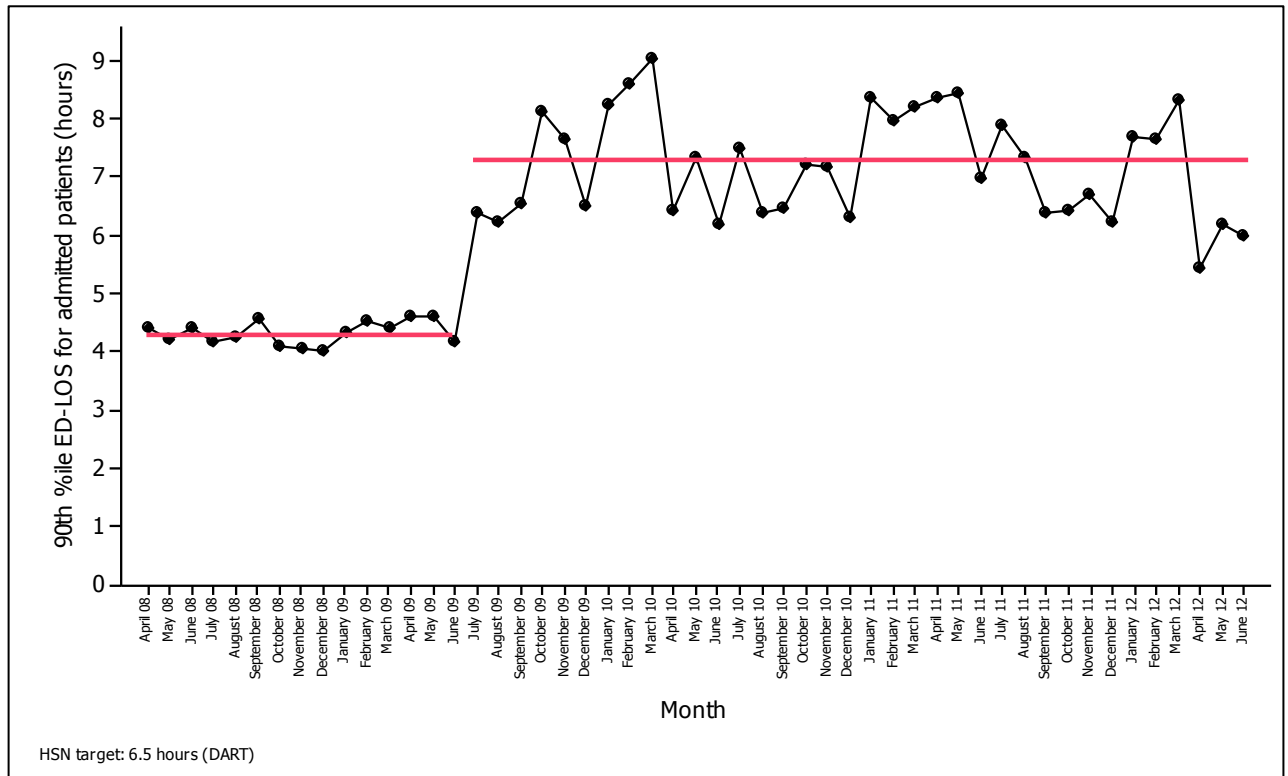


Exhibit 20:

90th percentile time to physician initial assessment – PIA
(April 2010 – June 2012)

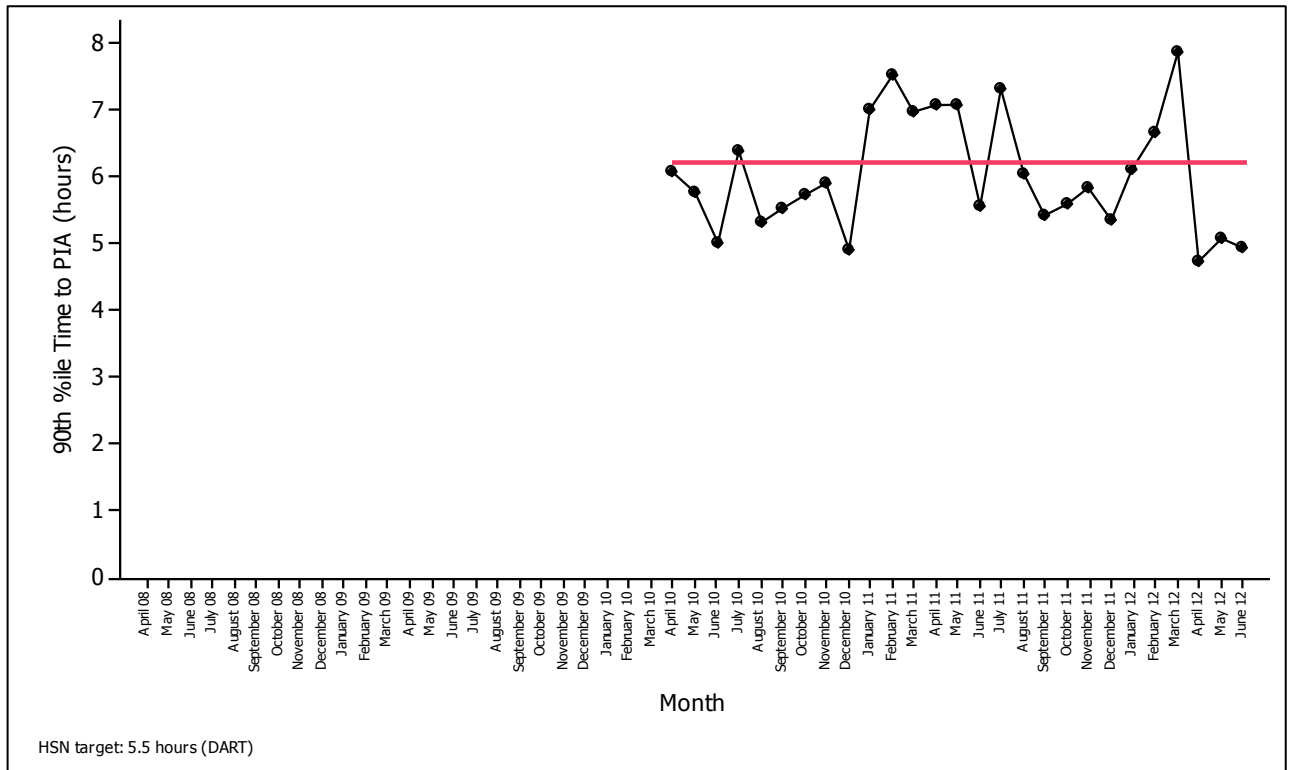


Exhibit 21:

Monthly 90th percentile ED-LOS over the last four fiscal years
(Ontario teaching hospitals).

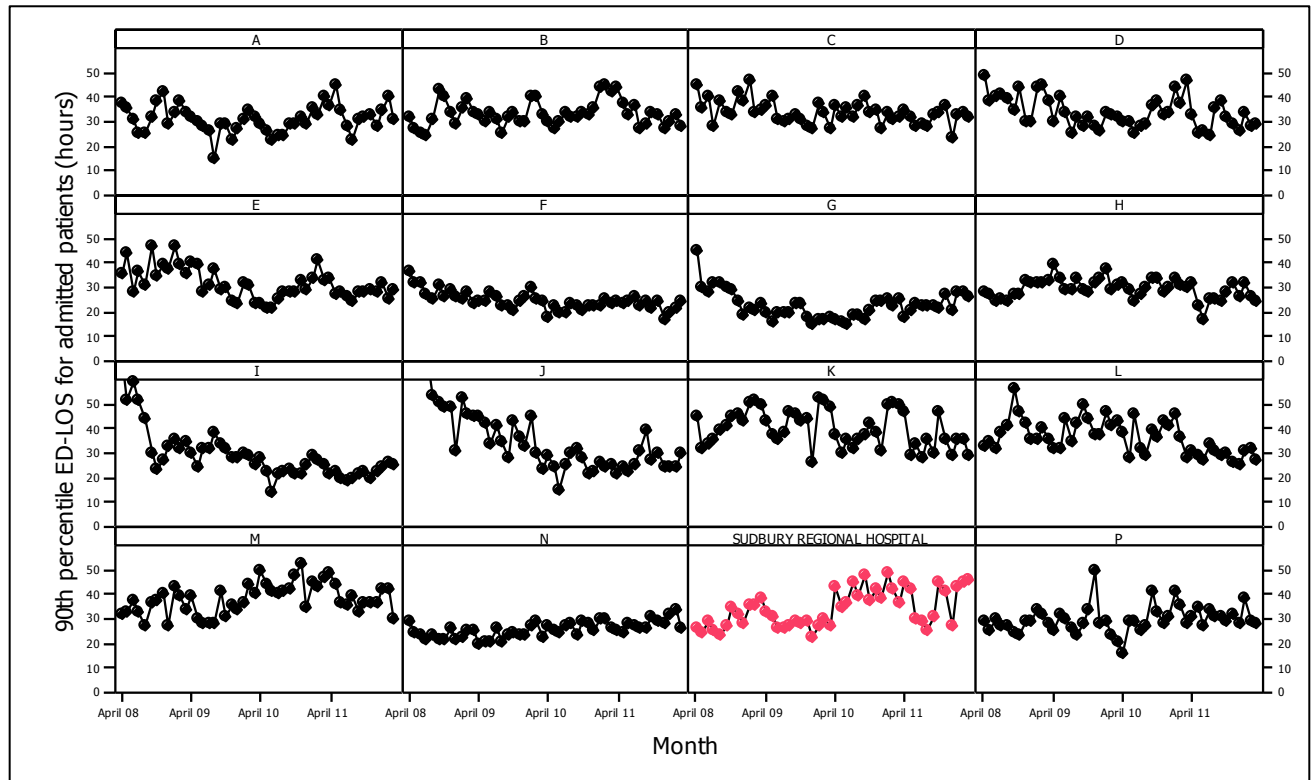


Exhibit 22:

Weekly New ALC-LTC Patients 12/13

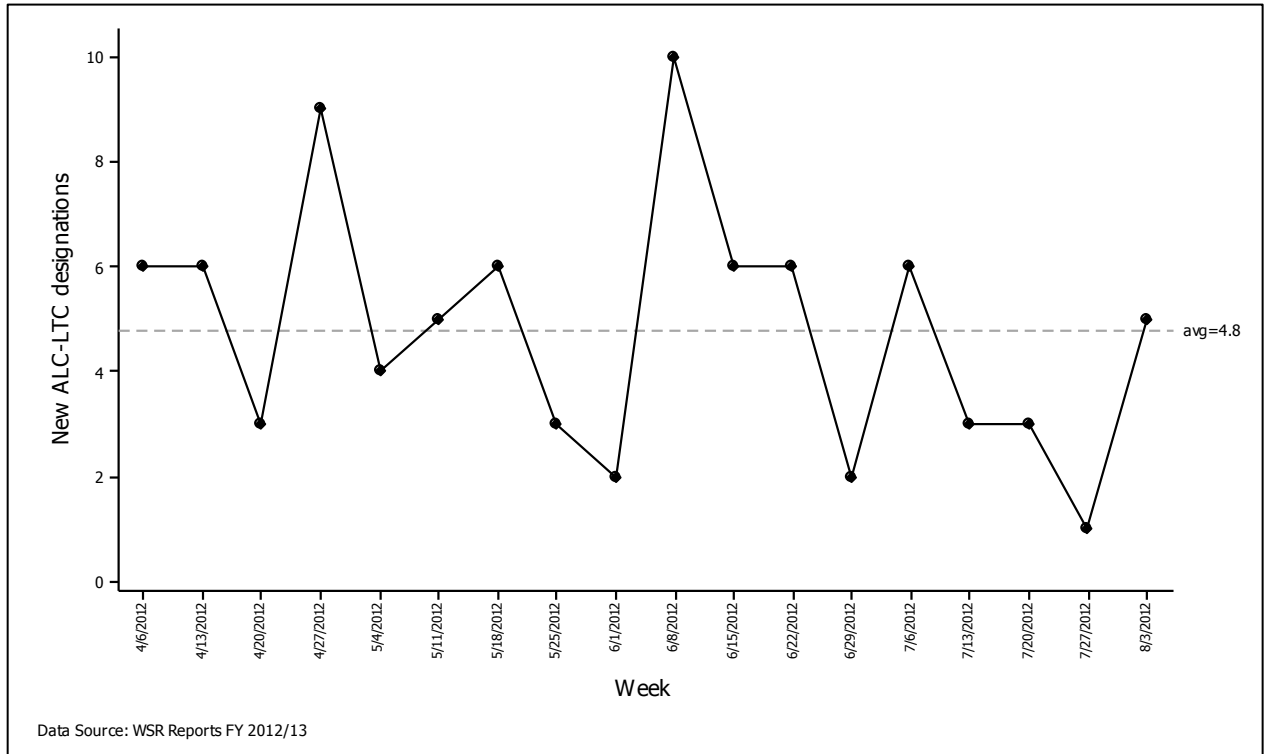


Exhibit 23:

ED PIP Initiatives Summary

EMERGENCY DEPARTMENT

Initiative (ED-PIP Phase 1)	Implementation Status	Sustained
Establish See-and-Treat area	COMPLETE	YES ¹
Establish Admit Overflow area	COMPLETE	YES
Establish Cardiac Observation Unit	COMPLETE	YES ²
Ambulance Offload Delay RN	COMPLETE	YES
Navigational Video for ED waiting room	COMPLETE	YES
Process Improvement Board	COMPLETE	PARTIAL
ED Nurse Navigator	COMPLETE	YES
Morning Team Huddles	COMPLETE	YES
Online LEAN Learning Module	COMPLETE	YES
Up-front Decision Maker	not implemented	
Clinical Decision Unit	not implemented	

¹ Implemented during ED-PIP Monday-Friday 1000-1600. Because of the success of this initiative, the Physician coverage will expand to 1000-2200 seven days per week as of September 2012.

² HSN also implemented an Acute Observation area in June 2012 to rapidly cycle acute patients through a limited number of ED stretchers.

BED ALLOCATION & PATIENT FLOW

Initiative (ED-PIP Phase 1)	Implementation Status	Sustained
Bed Empty Time Process	COMPLETE	YES
Inpatient Check Out Process	COMPLETE	YES ¹
Bed Allocation Bed Promise	COMPLETE	YES
ED Enhanced Whiteboard	COMPLETE	YES
Whiteboard for Patient Placement Plan	COMPLETE	YES
Portering	not implemented	

¹ HSN has also spread this initiative from 4 North to the other Medical Units (5 South and 6 South).

4 NORTH MEDICAL UNIT

Initiative (ED-PIP Phase 1)	Implementation Status	Sustained
Enhanced Daily Discharge Bullet Rounds	COMPLETE	YES
Charge Nurse Information Binders	COMPLETE	YES
Main Team Whiteboard	COMPLETE	YES
Discharge Checklist	COMPLETE	YES
Charge:Frontline 1-on-1 Huddles	COMPLETE	YES
Patient Whiteboard	COMPLETE	YES
Patient Discharge Pamphlet	COMPLETE	YES
Visual Management Tools / 5S	COMPLETE	YES

Exhibit 24: Hospital ALC-LTC versus Patients Awaiting Crisis in the Community

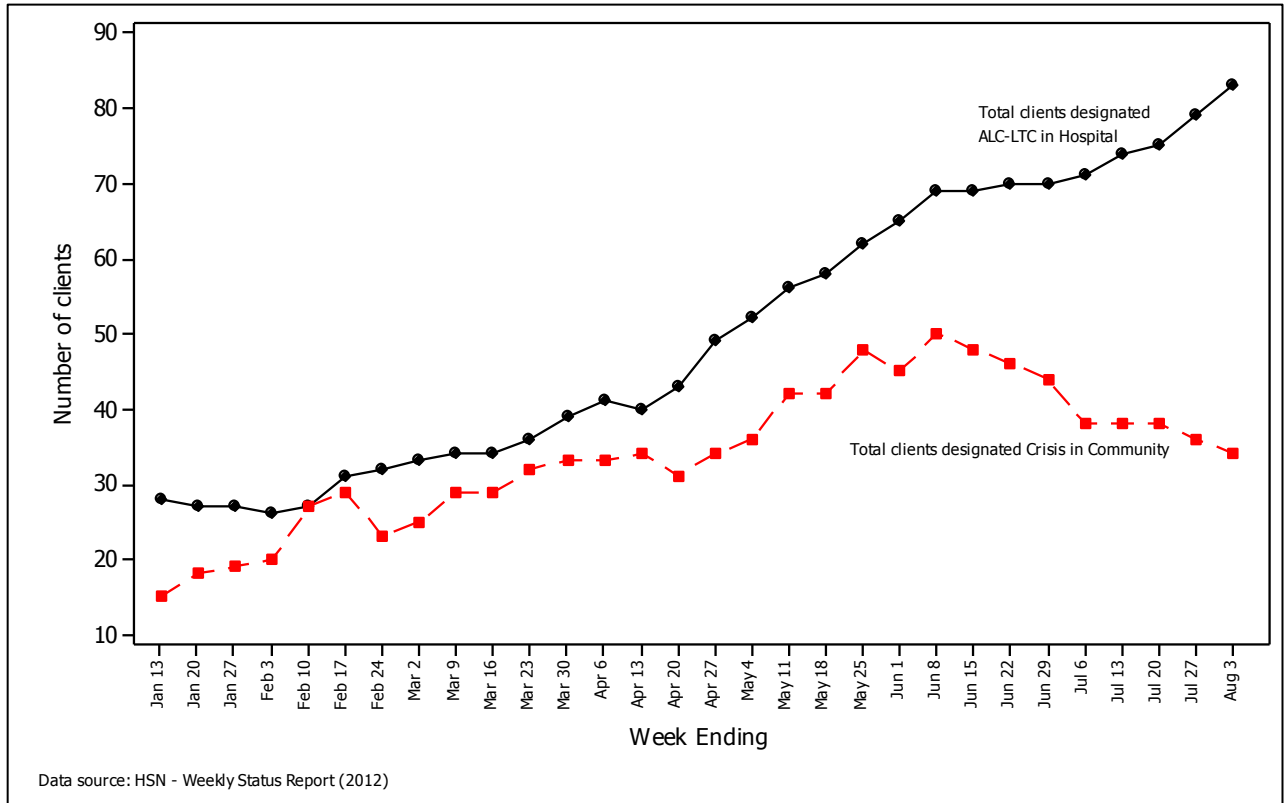


Exhibit 25: Estimated Conservable Bed Days (2010/2011)

Program Cluster	Typical Cases	Actual Acute LOS	Expected Acute LOS*	Conserv. Days
Cardiology	2,504	4.2	3.6	1,293
Orthopaedics	1,570	4.9	4.4	831
Cardiac Surgery	321	10.2	7.7	805
Pulmonary	1,175	6.5	6.0	606
Gastro/Hepatobiliary	1,153	4.7	4.2	603
Haematology	314	9.0	8.2	277
Neurosurgery	262	5.5	4.5	258
Vascular Surgery	370	6.2	5.7	213
Neurology	540	5.8	5.4	193
Gynaecology	589	2.7	2.5	124
General Surgery	955	6.9	6.8	102
Urology	726	3.8	3.7	75
Plastic Surgery	59	4.4	3.9	27
Otolaryngology	293	3.4	3.4	19
Ophthalmology	16	3.6	2.8	14
Dental/Oral Surgery	2	1.0	1.3	-
Endocrinology	274	4.2	4.3	-
Neonatology	1,799	2.3	2.4	-
Nephrology	109	6.2	6.3	-
Non-Acute	171	1.5	2.1	-
Obstetrics	1,862	1.8	1.9	-
Other Internal Medicine	839	5.5	5.9	-
Other Reasons	292	3.3	3.4	-
Psychiatry	179	6.0	7.7	-
Thoracic Surgery	219	6.2	6.6	-
Grand Total	16,593	4.5	4.2	5,441
* Expected LOS set at 90% of CIHI National ELOS				

Exhibit 26:

Distribution of Empty SJCCC beds

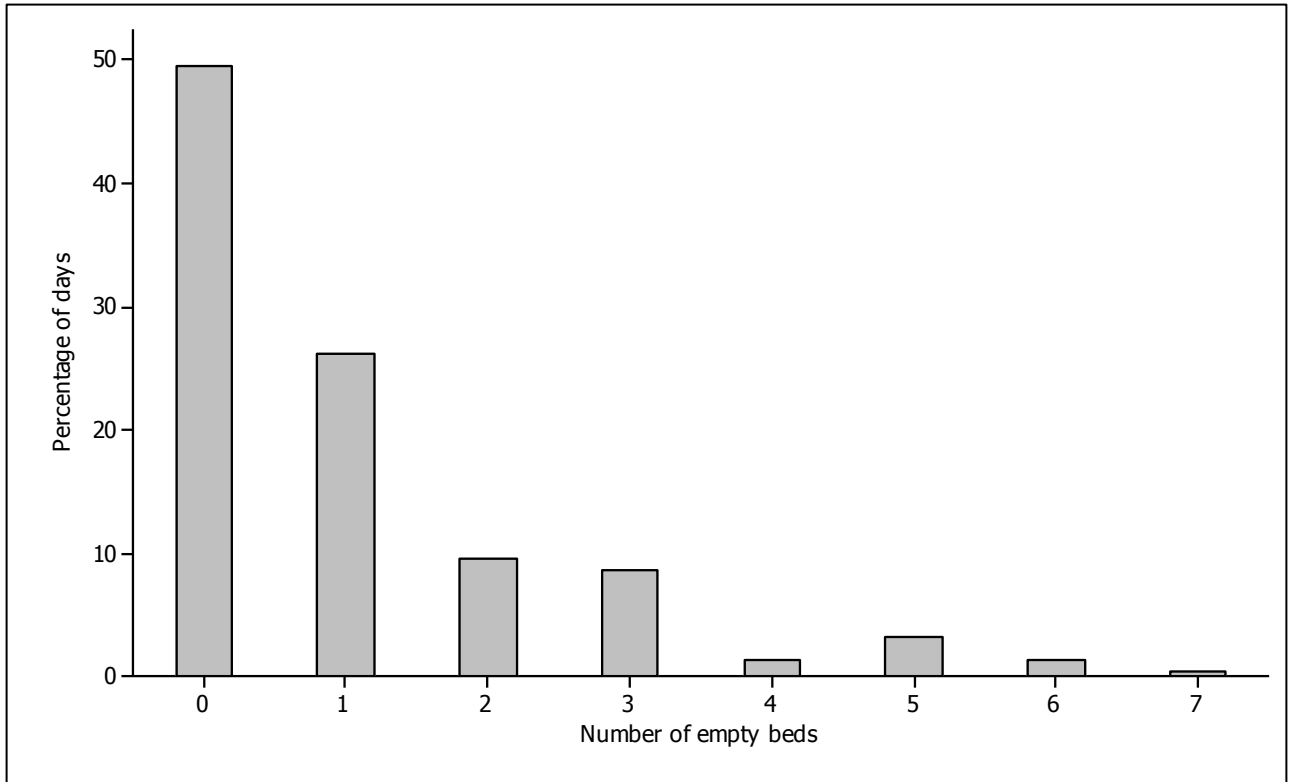


Exhibit 27:

Mental Health ANB Volumes

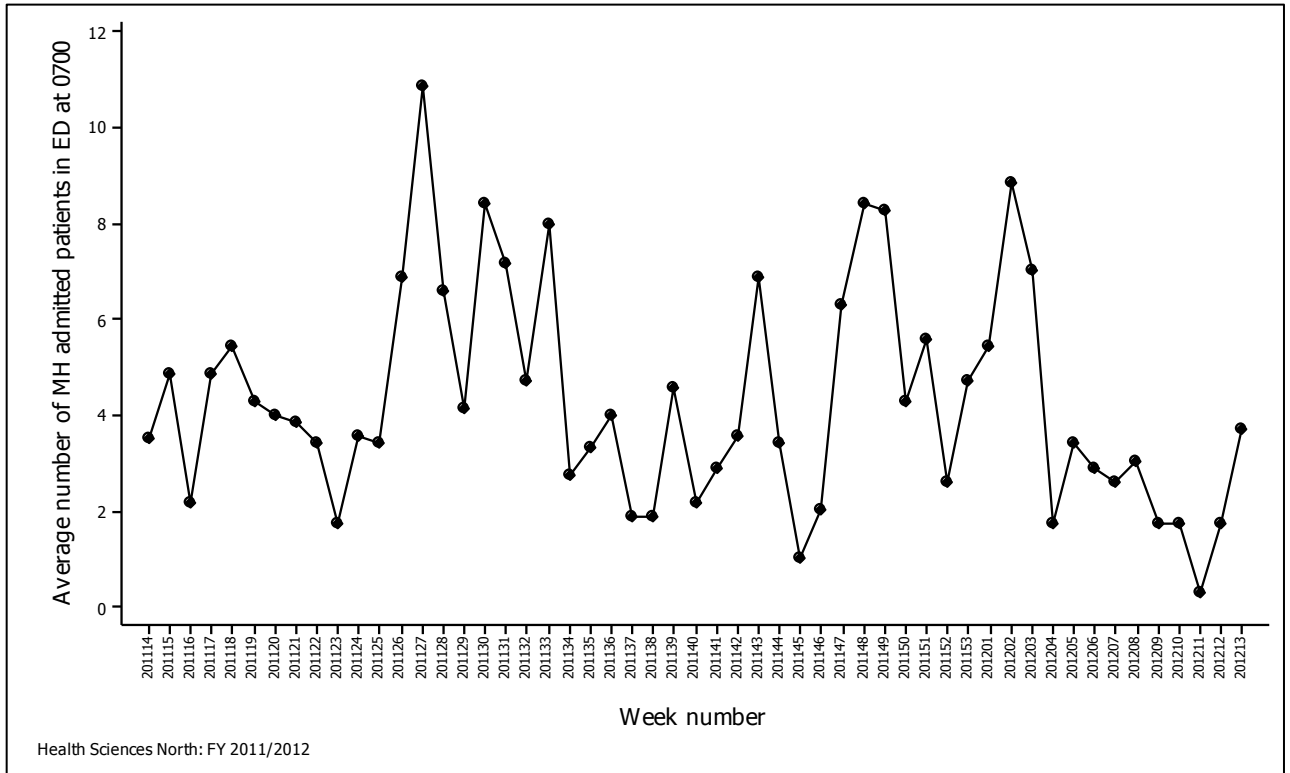
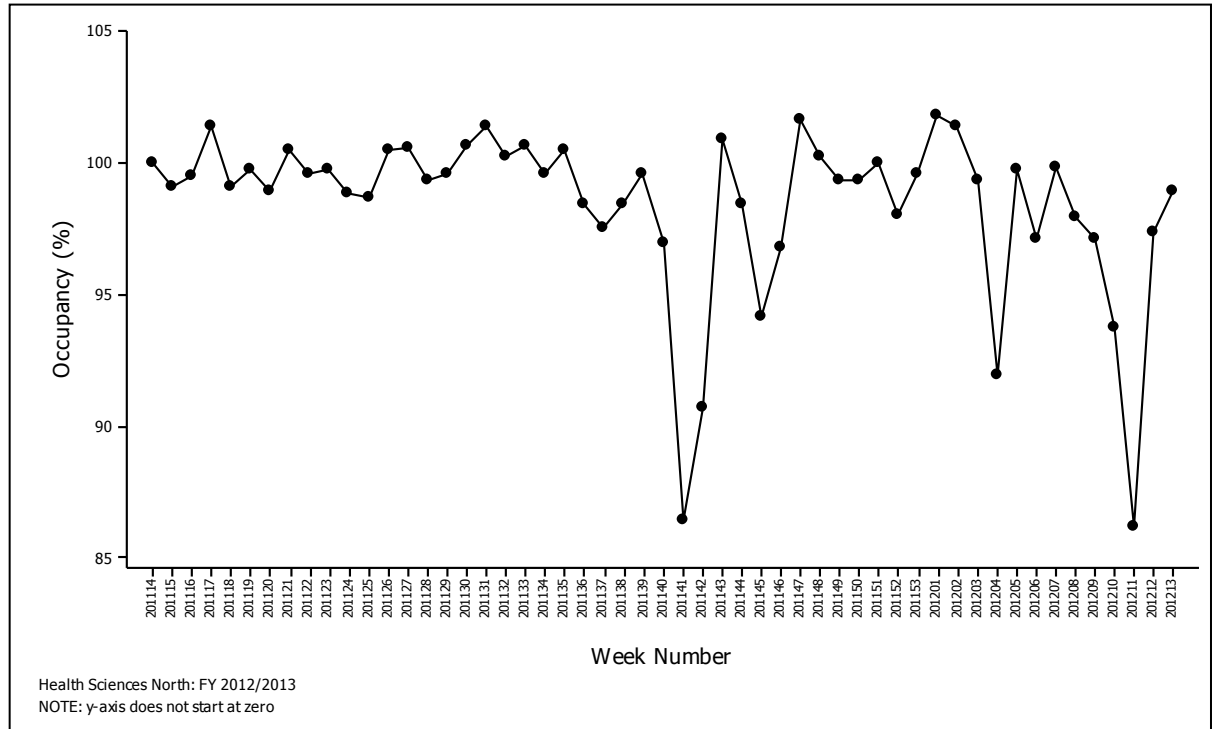


Exhibit 28:

Average Mental Health Occupancy



Appendix D: Document Review Inventory

Key documents that were used to inform this report are identified.

Document	Date
Operations Leadership Committee Budget Fiscal 2011/12/13	Monday, October 11, 2011
Copy of Status report on HIP-Peer Review Team edits	September 4, 2012
Organizational Charts	March 2012
Increase Base Funding Group a Teaching Hospital Facility	April 7, 2008
Financial Statements For The Four Months Ending July 31, 2012	July 31, 2012
Letter to Ron Sapsford re Sudbury Regional TBRHSC Hospitals re Teaching Hospital Funding	February 27, 2008
Alternate Level of Care Action Team Site Visit - Action Plan Report, North East Local Health Integration Network, Site Visit: June 21, 2011, NE LHIN Next Steps	Version August 22, 2011
Sudbury Peer Review	September 2012
North East LHIN Briefing Note	July 2012
HAPS 2012	July 3, 2012
HIP	December 14, 2011-Resubmission
HIP Global Indicators - Facility Trend, 959 HSN	July 10, 2012
HSN Financial Statement Supplementary	March 31, 2012
HSN Financial Statements	March 31, 2012
PDST Hospital Utilization Report, 959 HSN	
PCOP Allocation of Announced Funding	March 2012
Patient Flow Improvement Pilot - Final Report	March 2, 2011
IDP Improvement Objectives-	Draft June 19 2012
Key ALC Milestones In Sudbury - 2009 TO 2012	July 16,2012
Sudbury ALC Initiatives - 2007-08 through to 2011-12	July 10, 2012
ALC HSN	July 6, 2012
HSN ALC profile (WTIS ALC)	July 6, 2012
Alternate Level of Care Plan for Greater Sudbury Updated Feb 2 2012	Revised - March 29, 2012
NECCAC ALC Long Stay Project	March 29, 2011
OHA Alternate Level of Care (ALC)	July 2012
OHA Alternate Level of Care (ALC)	June 2012
OHA ALC and ED Wait times by LHIN April 2009- June 2012	June 2012
HSN Physician Length of Stay Report by Most Responsible Physician, Acute Inpatients Only Fiscal year 2010-2011	
HSN Bed Occupancy Report 2010 – July 2012	July 2012
HSN ALC Database	August 9, 2012
MEMO - HSN Patient Flow Data/Information Sharing Processes	September 27, 2012
Recruitment and Retention Program - NE LHIN -2011/12 Locum Activity	
Patient Flow Improvement Pilot-Final Report, Price Waterhouse Coopers	March 2,2011
Health Sciences North- Initial Analysis of Hospital Utilization Patterns – Hay Group	August 2012
HSN Bed Management-Staging Protocol	
Access to Care – Guidance for Alternate Level of Care The Provincial ALC Definition and Long Term Care (LTC) Designation	May 2012
Access to Care – Guidance for Alternate Level of Care The Provincial ALC Definition and To Be Determined (TBD) Designation	May 2012
HSN Quality Improvement Plan	2012 – 2013
Process Improvement Initiatives – Emergency Department	2011-2012
Process Improvement Initiatives – Bed Allocation & Patient Flow	2011-2012

Document	Date
Process Improvement Initiatives 4North & Medical Program	2011-2012
ED-PIP Presentation: Diagnosis Review	July 5, 2011
4North Charge Nurse Information Binder	
Physician LOS report by Most Responsible Provider	Various fiscal years
ALC Weekly Summary Report	
Admit to no bed and Mental Health HSN	
Bed Management	August 9, 2012
Bed Management	September 2012
Bed occupancy report	
HSN Patient Flow Information Sharing (with multiple embedded documents)	
Bed Management combined HSN LHIN report	
Master ALC database (snapshot)	
Patient Flow Dashboard	
Bed Management – Over Capacity & Staging Protocol	June 2012
WSR Reports	

Appendix E: Summary of Recommendations

- (1) The Board of Directors of HSN annually establish specific goals and/or objectives for the hospital and publicly account for them.**
- (2) The Board of Directors of HSN establish a mechanism to hold the senior leadership of the organization accountable for the achievement of their objectives for the organization.**
- (3) The Board of Directors of HSN tie achievement of the organization's objectives to higher levels of at-risk compensation for the senior leadership of the hospital.**
- (4) The Board of Directors of HSN ensure ALC is identified as a Priority One metric on the 2013/2014 QIP.**
- (5) The HSN CEO with support from the VP Finance/CFO undertake, on a monthly basis, a detailed review of performance to identify any deviations from plan and develop corrective actions required to return to plan.**
- (6) The Senior VP/COO of HSN develop specific plans for achieving wait time targets in both Primary Knee Replacements and TJR revisions.**
- (7) The Senior VP/COO of HSN establish a more disciplined process to monitor and manage surgical volumes to ensure activity does not exceed budgeted baseline.**
- (8) The VP Clinical Programs/CNE and the VP Medical and Academic of HSN ensure implementation of planned closures of surgical services at the Christmas Break and March Break.**
- (9) The HSN Senior VP/COO undertake an external review of Food Services functions with a goal of reducing costs without reducing quality for patients and visitors.**
- (10) The Senior VP/COO of HSN clarify and resolve the issues with respect to underfunding of Dialysis services provided by the hospital.**
- (11) The HSN CEO and CEO of NE LHIN clarify and resolve the issues with respect to underfunding of the Critical Care beds.**

- (12) The HSN CEO, with support from the VP of Finance, develop a more disciplined HIP monitoring process that will ensure a balanced budget at year end.**
- (13) The NE LHIN CEO continue to endorse HSN to receive the \$5.715M in the HSN PCOP funding request.**
- (14) The HSN Senior VP/COO and VP Medical and Academic undertake a review of the intended purpose of the Ambulatory Clinics operated on the first floor of HSN to ensure the hospital is only undertaking activity that appropriately belongs in the hospital.**
- (15) The HSN Senior VP/COO and VP Medical and Academic establish a process to develop a complete business case for each of the Ambulatory/Outpatient Clinics listed within the PCOP.**
- (16) The HSN Senior VP/COO and VP Medical and Academic establish a process to prioritize the requested Ambulatory/Outpatient Clinics on a need basis.**
- (17) The HSN CEO and VP Medical and Academic keep the Memorial Site open for current and future ambulatory programs and support programs.**
- (18) The HSN CEO and VP Medical and Academic ensure any new growth in ambulatory services will be subject to review and business case development.**
- (19) The HSN Board of Directors reinforce their expectation that the hospital achieve a balanced operating budget each year.**
- (20) The HSN CEO establish a financial accountability process that reflects the shared responsibilities of the executive and management team to achieve a balanced budget.**
- (21) The HSN Board of Directors to oversee the development of a Strategic Plan that will outline the priority goals of HSN for the next 10 years.**
- (22) The HSN CEO ensure that the strategic planning process is inclusive and consultative and that it be fully aligned with Ontario's Action Plan for Health Care and the priorities of the NE LHIN.**

- (23) The HSN, SJCCC and NE CCAC CEO's designate a senior leader to be part of a leadership team assigned the task of identifying and implementing strategies and priorities to deal with the level of ALC patients at HSN.**
- (24) The Board of Directors of HSN establish an annual goal whereby their executives are required to demonstrate specific examples of how they have exercised leadership at the NE LHIN or sub-LHIN level.**
- (25) The HSN VP Clinical Programs/CNE establish a process to align ALC designation practices related to "To Be Determined" with WTIS guidelines.**
- (26) The HSN VP Clinical Programs/CNE implement a process to ensure patients are appropriately designated "ALC Home" as per WTIS guidelines.**
- (27) The NE LHIN Senior Director ED and ALC prioritize development and implementation of a standardized Escalation process for NE LHIN hospitals.**
- (28) The HSN CEO assign accountability and oversight of HSN Escalation process to the Senior VP/COO or Clinical Programs VP/CNE.**
- (29) The NE LHIN Senior Director ED and ALC, in collaboration with HSN and the NE CCAC, establish a weekly target for "New ALC-LTC Designations".**
- (30) The HSN CEO and CCAC CEO to fully re-launch Home First philosophy.**
- (31) The NE LHIN Senior Director ED and ALC and NE CCAC CEO establish a review of service provider capacity concerns and update the status of previous review recommendations.**
- (32) The NE LHIN Senior Director ED and ALC and CEO NE CCAC to review all ALC Action Plan strategies related to Home First and determine requirements for implementation of "Home to Wait" 24/7 programming for the NE LHIN.**
- (33) The NE CCAC CEO and Senior Director of Client Services establish a process for a physician stakeholder meeting to identify current service concerns and improvement**

opportunities, and discuss opportunities for enhanced community programs.

- (34) The NE LHIN Senior Director ED and ALC and the NE CCAC CEO to establish a review and evaluation process for the IDP model and processes.**
- (35) The HSN VP Clinical Programs/CNE to update the discharge policy to include IDP model and realigned roles and accountabilities.**
- (36) The HSN VP Clinical Programs/CNE to clarify current roles and accountabilities for discharge planning and ALC management.**
- (37) The CCAC Senior Director Client Services to review CCAC Case Manager alignment and ensure units with high ALC volumes are assigned a “Complex” Case Manager.**
- (38) The VP Clinical Programs/CNE to re-launch the IDP model corporately following the recommended review and evaluation.**
- (39) The CCAC Senior Director for Client Services review the current CCAC referral process to ensure policies align with best practice and support early referral.**
- (40) The CCAC Senior Director for Client Services and HSN VP Clinical Programs/CNE establish a process for intensive case management review for all patients at risk of becoming ALC-LTC and include in the Escalation process.**
- (41) The HSN VP Clinical Programs/CNE ensure bed refusal processes are managed according to corporate policy.**
- (42) The HSN VP Clinical Programs/CNE and CCAC Senior Director Client Services develop a shared “Placement from Hospital” communication tool, identifying the process elements and timelines for completion.**
- (43) The CCAC Senior Director of Client services explore priority status for patients waiting LTC placement at SJCCC to optimize flow across all transition points.**
- (44) The CCAC Senior Director of Client services establish a consultative process including physicians and SJCCC to**

review community and ED referral processes and identify opportunities as related to delays and assessment processes.

- (45) The SJCCC VP Clinical Services undertake process mapping of CCC referral processes and develop interim strategies to ensure no transfer delays between facilities.**
- (46) The SJCCC VP Clinical Services review opportunities for CCC to expand Home First supports to HSN including potential care path amendments for frail elderly.**
- (47) The SJCCC VP Clinical Services conduct a six month evaluation of revised Admission Criteria.**
- (48) The NE LHIN Senior Director ED and ALC, NE CCAC CEO and the VP Clinical Programs/CNE immediately meet to review priority placement status for HSN; develop a formalized process for ongoing review; and identify/implement strategies to strengthen the balance between hospital and community partners.**
- (49) The HSN VP Clinical Programs/CNE to include the ALC rate with monthly trending, target, mean and statistical control limits in performance monitoring reports.**
- (50) The HSN CEO continue operations of the 30 ALC beds at Memorial Site until September 1, 2013.**
- (51) The NE LHIN CEO consider the continuation of the funding arrangement for the Memorial beds until August 31, 2013.**
- (52) The HSN VP Clinical Programs/CNE to investigate the cause(s) for increased conservable acute beds in FY 2011/12 in both Medicine & Rehabilitation and Critical Care programs.**
- (53) The HSN VP Clinical Programs/CNE to review 11/12 conservable bed data to determine continued opportunity in Cardiology, Cardiac Surgery and Orthopedics.**
- (54) The CEO HSN and CEO NBRHC to work collaboratively to develop and implement a more effective structure for managing MH patients between the two organizations.**
- (55) The HSN Senior VP/COO to explore permanent funding to allow for continued implementation of the MH Transitional Discharge Unit.**